MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2601 02580

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the medical director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
c. LENGTH OF STAY IN 1b: 8-8-60
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Children's Center

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: D. C. — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 1427 Montello Avenue, N.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Conrad	Arnold	Anderson	March	24	1961

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	C		12-27-43	17 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student		D.C.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Joseph Anderson	Connie Bristow

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No		Children's Center File, Laurel, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Third Degree Burns	Sudden
DUE TO (b)	Epilepsy	All life
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		

917.7

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
	Exposure to live steam (he broke the heating pipe)

20c. TIME OF INJURY Hour 5:20 p.m. Month, Day, Year 3-24-61 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☒	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
		Institution	Laurel, Anne Arundel, Maryland

21. I **certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gustave H Faubert M.D. M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
3/24/61 DATE SIGNED

EXAMINER'S NAME (Type): Gustave H. Faubert, M.D.
Address (Street, city, town, or county): Glen Burnie, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or country) (State)
Burial	3/29/61	Carver Park	Laural Md.

23. FUNERAL DIRECTOR	ADDRESS	24a. RECD BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
Ashwood Funeral Home By Willie E. Ashwood	4609-14th St. NW.	MAR 28 '61	Arthur S. Kraus

VS. AISME 5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2602 Reg. Dist. No. 02581

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the register prior to burial, cremation, or removal.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital DOA

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Davidsonville
d. STREET ADDRESS: none
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First HARRY Middle ARMIGER Last

4. DATE OF DEATH: Month March Day 14 Year 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 27, 1894
9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Foreman
10b. KIND OF BUSINESS OR INDUSTRY: County Road Dept.
11. BIRTHPLACE (State or foreign country): A.A. County, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Armiger
14. MOTHER'S MAIDEN NAME: Martha Lowe

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW I
16. SOCIAL SECURITY NO.: 216-42-6800
17. INFORMANT Address: Mrs. Annie Asquith Armiger- Wife- same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

434.4

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: [signature] M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 3/17/61

EXAMINER'S NAME (Type): Elmer C. Linhardt

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: March 18, 1961
22c. NAME OF CEMETERY OR CREMATORY: Davidsonville Methodist Cemetery
22d. LOCATION (City, town, or county) (State): Davidsonville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOPPING FUNERAL HOME — Annapolis, Maryland

24a. REC'D BY REGISTRAR DATE: MAR 20 '61
24b. REGISTRAR'S SIGNATURE: Clifton L. Hanna

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2603 02582

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): (Dead on Arrival) Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
e. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis
d. STREET ADDRESS: 20 Woodlawn Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Eliza — Middle: J — Last: BASSFORD
4. DATE OF DEATH: Month: March — Day: 28 — Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: March 7, 1885
9. AGE (In years last birthday): 76 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: own Home
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George Aisquith
14. MOTHER'S MAIDEN NAME: Mary Ireland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.: none
17. INFORMANT — Address: Mr James A. Bassford- Son- Same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute dilatation of the Heart (Rupture of Myocardium)
434.4
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~XXXXXXX~~) attended the deceased from June 24, 1959 to Mar. 28, 1961, that (I) (~~XXX~~) last saw the deceased alive on Mar. 28, 1961, and that death occured at 10:10 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Albert L. Anderson M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/29/61
22c. PHYSICIAN'S NAME (Type): Albert L. Anderson
22d. ADDRESS: 44 Southgate Ave., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: March 31, 1961
23c. NAME OF CEMETERY OR CREMATORY: Cedar Bluff Cemetery
23d. LOCATION (City, town or county) (State): Annapolis, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Hopping Funeral Home
ADDRESS: Annapolis, Md.
25a. REC'D BY REGISTRAR DATE: APR 3 '61
25b. REGISTRAR'S SIGNATURE: Clifton S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

s after death: Page 4

by the funeral director

AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within
tained by the hospital or attending physician.
L DIRECTOR: After this certificate has been signed by the attending physician and completely fill
ould be detached for use as the burial-transit permit. Then please remove carbon papers. Page

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VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G283 3/20/61 mh

2604

CERTIFICATE OF DEATH

Reg. Dist. No. 02583

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis, Maryland
c. LENGTH OF STAY IN 1b: 15 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: USNH, Annapolis, Maryland

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis, Maryland
d. STREET ADDRESS: 114 Duke Of Gloucester Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elizabeth; Middle: Rea; Last: Benson

4. DATE OF DEATH: Month: March; Day: 11; Year: 1961

5. SEX: Female

6. COLOR OR RACE: Cauc

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11-29-89

9. AGE (In years last birthday): 71 70 yrs. IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: ———————

11. BIRTHPLACE (State or foreign country): California

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Alex Thompson

14. MOTHER'S MAIDEN NAME: Moore Mary Bernard

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Howard H J Benson — Address (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Rheumatic valvulitis, inactive with deformity	10 years
DUE TO	of the Aortic Valve.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Rheumatic heart disease inactive, Aortic Insufficiency	10 yrs
DUE TO (c)	Hyperthyroidism without evident goiter.	- -

2520

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 24 Feb 61, 1961, to 11 MAR, 1961, that I last saw the deceased alive on 10 MAR, 1961, and that death occurred at 1210 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: R.G. Williams M.D.

ADDRESS (Street, city or town, state): US. NAVAL HOSPITAL, ANNA. MD.

DATE SIGNED: 11MAR61

PHYSICIAN'S NAME (Type): R.G. Williams Jr. CDR MC USN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-14-1961

22c. NAME OF CEMETERY OR CREMATORY: Arlington National

22d. LOCATION (City, town, or county) (State): Arlington V

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons

ADDRESS: Annapolis Md

24a. REC'D BY REGISTRAR DATE: MAR 14 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

(I)

(2)

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The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2605

CERTIFICATE OF DEATH

Reg. Dist. No. 02584

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Linthicum
c. LENGTH OF STAY IN 1b: 5 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 903 WANDA Rd. Linthicum

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Balto A H.Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): linthicum
d. STREET ADDRESS: 903 Wanda Rd. 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY Middle ANNA Last BIRSNER

4. DATE OF DEATH: Month Mar Day 8 Year 1961

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 13 1893

9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10b. KIND OF BUSINESS OR INDUSTRY: House Work

11. BIRTHPLACE (State or foreign country): Balto. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Jendrasz Kiewicz

14. MOTHER'S MAIDEN NAME: Agnes Rutkowski

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 213056893

17. INFORMANT: Herman H. Birsner Address: 903 Wanda Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia
DUE TO (b): Rheumatoid arthritis, general
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 722.0

INTERVAL BETWEEN ONSET AND DEATH: 12 Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 57 to Mar 8 1961 that I last saw the deceased alive on Mar 7, 1961, and that death occurred at 7 10 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Joseph Taler M.D.
ADDRESS (Street, city or town, state): 102 Bar Blvd. N.E.
DATE SIGNED: 3-8-61

PHYSICIAN'S NAME (Type): JOSEPH TALER GLEN BURNIE, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: March 11-61
22c. NAME OF CEMETERY OR CREMATORY: Cathedral Cem.
22d. LOCATION (City, town, or county) (State): Old Frederick Rd Balto Md

23. FUNERAL DIRECTOR'S SIGNATURE: Nagel Bros ADDRESS: 1800 E. Lombard St.

24a. REC'D BY REGISTRAR DATE: MAR 10 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director. page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2606 Items 7 Film G203 3/27/61 lwk

02585

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 164 Third St.,
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: — Last: BLUNT

4. DATE OF DEATH: Month: March — Day: 6 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 24, 1907

9. AGE (In years last birthday): 53 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Oysterman

10b. KIND OF BUSINESS OR INDUSTRY: Seafood

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA. U.S.

13. FATHER'S NAME: Charles Blunt

14. MOTHER'S MAIDEN NAME: Elizabeth Hall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs Emma Cook — Address: 87 Charles St, Annapolis.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 7 da.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Chronic Diffuse Glomerulephritis — 1 yr.
DUE TO (c): Pulmy Edema

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (DECEASED) attended the deceased from Mar. 3, 1961, to Mar. 6, 1961, that (I) (he) last saw the deceased alive on Mar. 6, 1961, and that death occured at 4:00 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Theodore H. Johnson M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3-7-61

22c. PHYSICIAN'S NAME (Type): Theodore H. Johnson

22d ADDRESS: 37 Calvert St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3-10-61

23c. NAME OF CEMETERY OR CREMATORY: Bunker Hill

23d. LOCATION (City, town or county) (State): Annapolis, Md

24 FUNERAL DIRECTOR'S SIGNATURE: Harris & Johnson — ADDRESS: Annapolis, Md

25a. REC'D BY REGISTRAR: MAR 10 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2607 Items 7, 8 & 9 Filed 6603 3/21/61 lwk

CERTIFICATE OF DEATH

02586

1 PLACE OF DEATH
a COUNTY: Anne Arundel, MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Galesville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission)
a STATE: Md.
b. COUNTY: A. A.
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Galesville, Md.
d STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Jan Middle Last Brzezinski

4. DATE OF DEATH: Month March Day 13 Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: Dec. 11, 1889

9 AGE (In years last birthday): 71 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13 FATHER'S NAME:

14 MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17 INFORMANT Address:

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Immediate

DUE TO (b): Arteriosclerotic heart disease — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): congestive heart failure

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from March 1, 19 61 to March 13 1961, that (I) (we) last saw the deceased alive on March 7 1961, and that death occurred at 8 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Willard F. Smith M.D.

ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 3/14/61

22c PHYSICIAN'S NAME (Type): WILLARD F. SMITH, MD

22d. ADDRESS: Shadyside, Md.

23a BURIAL, CREMATION REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/16/61

23c NAME OF CEMETERY OR CREMATORY:

23d. LOCATION (City, town, or county) (State):

24 FUNERAL DIRECTOR'S SIGNATURE: [illegible] ADDRESS:

25a. REC'D BY REGISTRAR DATE: MAR 17 '61

25b REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2608

CERTIFICATE OF DEATH

U2587

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN this: 3 mos. 28 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 618 West Isabella Street
a. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Sarah — Middle: L. — Last: Burris

4. DATE OF DEATH: Month: 3 — Day: 23 — Year: 19 61

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 7, 1909

9. AGE (In years last birthday): 51 ? yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed

10b. KIND OF BUSINESS OR INDUSTRY: ———

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Irving S. Parsons

14. MOTHER'S MAIDEN NAME: Mattie Daniels

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 218 34 7719

17. INFORMANT: Unknown — Address: Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH

420

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Myocardial Infarction

DUE TO (c): Hypertensive and Arteriosclerotic Cardiovascular Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.): ———

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year: ——— 19 — 20d. INJURY OCCURRED: While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ——— — 20f. (City or town) (County) (State): ———

21. I certify that (I) (this hospital) attended the deceased from 11/25, 1960, to 3/23/, 19 61 that (I) (we) last saw the deceased alive on 3/23/, 19 61, and that death occured at 2:00 a.m. from the causes and on the date stated above.

22a. SIGNATURE: Hildegard Heard Reissman M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 3/23/61

22c. PHYSICIAN'S NAME (Type): Hildegard Heard Reissman, M. D.

22d. ADDRESS: Crownsville State Hospital, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 3-26-61 — 23c. NAME OF CEMETERY OR CREMATORY: Green Acre Cem. — 23d. LOCATION (City, town or county) (State): Salisbury, Md

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Thornton B. Jolley - Salisbury, Md

25a. REC'D BY REGISTRAR DATE: MAR 29 '61 — 25b. REGISTRAR'S SIGNATURE: Clarence E. Hearn

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2609 **CERTIFICATE OF DEATH** 02588

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: MARYLAND 10 mos, 20 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Tacomo Park
d. STREET ADDRESS: 300 Vine Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Thomas; Middle T; Last Byrd

4. DATE OF DEATH: Month 3; Day 17; Year 1960

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12/3/1901

9. AGE (In years last birthday): 59 yrs. IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Roofer

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (County & State, or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Byrd

14. MOTHER'S MAIDEN NAME: Sylvia ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Hospital Records Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 1 [illegible] X Carcinoma of the Esophagus
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour ~~a.m.~~ p.m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4/27 ....., 1960, to 3/17 ....., 1961, that (I) (we) last saw the deceased alive on 3/17/61 .19.. .. , and that death occured at 4:20 a.m., from the causes and on the date stated above.

22a. SIGNATURE: Hildegard H. Reissmann

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Hildegard H. Reissmann, M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ M.D. 3/17/61

22d ADDRESS: Crownsville State Hospital, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3-24-61

23c. NAME OF CEMETERY OR CREMATORY: Harmony

23d. LOCATION (City, town or county) (State): Md

24 FUNERAL DIRECTOR'S SIGNATURE: A. N. Bacon

ADDRESS: 1722 7th St. N.W.

25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

DATE MAR 28 '61 Arthur S. Kraus

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2610

CERTIFICATE OF DEATH

02589

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1. PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND	2 USUAL RESIDENCE (Where deceased lived If institution Res'dence before admission) a. STATE: Maryland b. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort George G. Meade c. LENGTH OF STAY IN 1b: -	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Fort George G. Meade
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: United States Army Hospital	d STREET ADDRESS: Quarters # 7639-A e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: PATRICIA	Middle: JEANNETTE	Last: BYRNES	4. DATE OF DEATH	Month: MARCH	Day: 8	Year: 19 61		
5. SEX: Female	6. COLOR OR RACE: Cau	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ N/A DIVORCED ☐	8. DATE OF BIRTH: 1:12 PM 8 March 1961	9. AGE (In years last birthday): - yrs.	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS: Hours: 1	Min: 8	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): -	10b. KIND OF BUSINESS OR INDUSTRY: -	11. BIRTHPLACE (State or foreign country): Maryland	12 CITIZEN OF WHAT COUNTRY? USA						
13. FATHER'S NAME: Robert Byrnes	14. MOTHER'S MAIDEN NAME: Lorraine Cadorette								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): - (If yes, give war or dates of service): -	16. SOCIAL SECURITY NO.: -	17. INFORMANT: Father	Address: Qtrs 7639-A Ft Geo G. Meade, Md.						

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Possible brain damage — INTERVAL BETWEEN ONSET AND DEATH

760.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Frank Breech Delivery

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County) (State)

21. I certify that (I) (~~the hospital~~) attended the deceased from 1:12 PM 8 Mar 61 to 2:20 PM 8 Mar 61 that (I) (We) last saw the deceased alive on 8 Mar 61 19 , and that death occurred at 2:20 P.m. from the causes and on the date stated above

22a SIGNATURE: Herman I. Rosenberg Capt MC M.D	ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☒		22b. DATE SIGNED: 9 Mar 61
22c. PHYSICIAN'S NAME (Type): HERMAN I. ROSENBERG, Capt., M.C.	22d. ADDRESS: USA Hosp Ft Geo G. Meade, Md.		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE THEREOF: March 11, 1961	23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Catholic Cem.	23d LOCATION (City town, or county) (State): Allegheny Co. Maryland	
24 FUNERAL DIRECTOR'S SIGNATURE: DeWitt Donaldson	ADDRESS: Laurel, Maryland	25a. REC'D BY REGISTRAR DATE: MAR 14 61	25b REGISTRAR'S SIGNATURE: Arthur S. Drake	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2611 **CERTIFICATE OF DEATH** 02590

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 4 Mos.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Homewood Convalescent Home

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 65 East Street.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ursula — Middle: Hook — Last: CAMPBELL

4. DATE OF DEATH: Month: March — Day: 10 — Year: 1961

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 10-12-98

9. AGE (In years last birthday): 62 yrs.

IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (County & State, or foreign country): BALTIMORE MD

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: JOHN HOOK

14. MOTHER'S MAIDEN NAME: JOSEPHINE LAUDUS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT Address: MRS MARCELLA CICLARONA (2)

18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Circulatory Collapse — INTERVAL BETWEEN ONSET AND DEATH: —

DUE TO (b): Cachexia — 2 mos.

DUE TO (c): Carcinoma Cervix, Stage IV — 13 mos.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. I / I A

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3/25, 1960 to 3/10, 1961, that (I) (we) last saw the deceased alive on 3/2 1961, and that death occured at 8:57 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Stuart M. Christhilf M.D.

22b. DATE SIGNED

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): Stuart M. Christhilf

22d. ADDRESS: 69 Franklin St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3-13-1961

23c. NAME OF CEMETERY OR CREMATORY: St Marys Cemt

23d. LOCATION (City, town or county): Annapolis (State): Md

24. FUNERAL DIRECTOR'S SIGNATURE: John M. Jay & Sons

ADDRESS: Annapolis, Md.

25a. REC'D BY REGISTRAR DATE: MAR 14 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Hurd

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2612 — Reg. Dist. No. 02592

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater
c. LENGTH OF STAY IN 1b: 60 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater,
d. STREET ADDRESS: Rt 1 Box 285
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Harry — Middle: — Last: Collison
4. DATE OF DEATH: Month: March — Day: 2, — Year: 1961

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb. 22, 1882
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter
10b. KIND OF BUSINESS OR INDUSTRY: Boarding Homes
11. BIRTHPLACE (State or foreign country): Mayo, Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Collison
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Karl R. Collison, — Address: Rt 1 Box 285 Edgewater, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cardiac failure	10 hours
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Arteriosclerotic cardio-vascular disease	5 years
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from June 20, 1958 to March 1, 1961 that I last saw the deceased alive on March 2, 1961, and that death occurred at 9:15 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Sylvia M. Lim M.D. — ADDRESS (Street, city or town, state): Rt 1 Box 227-M — DATE SIGNED: 3/2/61

PHYSICIAN'S NAME (Type): Sylvia M. Lim — Edgewater, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar 4-1961
22c. NAME OF CEMETERY OR CREMATORY: Mayo Memorial Cem
22d. LOCATION (City, town, or county): Mayo (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons — ADDRESS: Annapolis Md.
24a. REC'D BY REGISTRAR DATE: MAR 6 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2613

CERTIFICATE OF DEATH

02593

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: MARYLAND 5 yrs. 7mo. 19 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Res'dence before admiss on)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, wr'te RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 27 N. Carey Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Garrison; Middle: ; Last: Cummings

4. DATE OF DEATH: Month: 3; Day: 4; Year: 1961

5. SEX: Male,

6. COLOR OR RACE: Negro

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 10/1/1875

9. AGE (In years last birthday): 85 yrs. IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waiter

10b. KIND OF BUSINESS OR INDUSTRY: ----------

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Cummings

14. MOTHER'S MAIDEN NAME: Elizabeth ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Hospital Records — Address:

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Paralytic Ileus

DUE TO (b): Incarcerated Inguinal Hernia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Advanced Arteriosclerotic Cardiovascular Disease with old myocardial Infarction

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): ----------

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): -------

20f. (City or town) (County) (State): -------

21. I certify that (I) (this hospital) attended the deceased from 7/15/55 to 3/4/61, that (I) (we) last saw the deceased alive on 3/4/61, and that death occured at 12:45 a.m. from the causes and on the date stated above.

22a. SIGNATURE Hildegard Heard Reissman M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3/6/61

22c. PHYSICIAN'S NAME (Type): Hildegard Heard Reissman, M. D.

22d. ADDRESS: Crownsville State Hospital, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/10/61

23c. NAME OF CEMETERY OR CREMATORY: Mt. Auburn

23d. LOCATION (City, town or county) (State): Balt...

24. FUNERAL DIRECTOR'S SIGNATURE: Charles Kehan

ADDRESS: 862 Hadaway Ave

25a. REC'D BY REGISTRAR DATE MAR 9 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2614 — 02594

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: ANne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): ANne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MAryland — b. COUNTY: Anne ARundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - CHurchton
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Melvin — Middle: — Last: DASHIELLS

4. DATE OF DEATH: Month: MArch — Day: 25 — Year: 1961

5. SEX: MAle

6. COLOR OR RACE: NEGro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: September 15, 1912

9. AGE (In years last birthday): 48 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): MARyland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Perry Dashiells

14. MOTHER'S MAIDEN NAME: Macklin Kane

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: 212-14-4026

17. INFORMANT: Address: Rose Dashiells Churchton MD

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): '57X Carcinoma of pancreas & metastases
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 18 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (~~Accompanied~~) attended the deceased from Mar. 17, 1961 to Mar. 25, 1961, that (I) (XX) last saw the deceased alive on Mar. 25, 1961, and that death occured at 11:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Willard F. Smith M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3/27/61

22c. PHYSICIAN'S NAME (Type): Willard SMith

22d. ADDRESS: SHadyside, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3-30-1961

23c. NAME OF CEMETERY OR CREMATORY: Mt. Sigon

23d. LOCATION (City, town or county) (State): Marion Station Md.

24. FUNERAL DIRECTOR'S SIGNATURE: William Bassett — ADDRESS: Annd. Md

25a. REC'D BY REGISTRAR DATE: MAR 30 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2615 **CERTIFICATE OF DEATH** 02595

Item 7 Film G283 3/23/61 iwk

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X RURAL - Crownsville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William Middle: B. Last: DAWSON
4. DATE OF DEATH: Month: March Day: 15 Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ widowed
8. DATE OF BIRTH: December 25, 1884
9. AGE (In years last birthday): 76 yrs. IF UNDER 1 YEAR Months: Days: IF UNDER 24 HRS. Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER
10b. KIND OF BUSINESS OR INDUSTRY: Ret.
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?: U.S.
13. FATHER'S NAME: "UNK"
14. MOTHER'S MAIDEN NAME: "UNK"
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: HOWARD B. DAWSON Address: #2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Massive Gastrointestinal hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 da

I I V

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Duodenal Ulcer — 2 wks.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour e.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County, (State)

21. I certify that (I) (~~DIDXXXXXX~~) attended the deceased from Mar. 12, 1961 to Mar. 15, 1961, that (I) ~~DID~~ last saw the deceased alive on Mar. 15, 1961, and that death occured at 10:30 P.M., from the causes and on the date stated above

22a. SIGNATURE: M.D.

22b. DATE SIGNED:

ATTENDING PHYS. XX MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): Richard N. Peeler

22d. ADDRESS: 121 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 3-18-61
23c. NAME OF CEMETERY OR CREMATORY: Baldwin Memorial
23d. LOCATION (City, town or county): Crownsville (State): Md.

24. FUNERAL DIRECTOR'S SIGNATURE: John M Taylor & Sons ADDRESS: Annapolis, Md.

25a. REC'D BY REGISTRAR DATE: MAR 20 '61
25b. REGISTRAR'S SIGNATURE: Esther L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

Iter 21 Film 283 3-4

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2616

02596

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

1. PLACE OF DEATH
   a. COUNTY: A. A. Co.
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
   c. LENGTH OF STAY IN 1b: MARYLAND
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A. Anne Arundel General

2. USUAL RESIDENCE (Where deceased lived, If Institution: Res dence before admiss.on)
   a. STATE: M D
   b. COUNTY: AACO
   c. CITY OR TOWN (If outs de corporate limits, write RURAL and give nearest town): Millersville
   d. STREET ADDRESS: Rd. 2 - Box 86
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Ellis; Middle: Ward; Last: Dillon

4. DATE OF DEATH: Month: 3; Day: 5; Year: 1961

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-8-60

9. AGE (In years last birthday): [illegible] yrs. IF UNDER 1 YEAR: Months: 6; Days; IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Baltimore Md

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Ellis Ward Dillon

14. MOTHER'S MAIDEN NAME: Lorettafern Stacy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Ellis W. Dillon (2) Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): asphyxia
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH: Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Blanket over subject head & face

20c. TIME OF INJURY: Hour a.m. p.m. 3-5- Month, Day, Year 1961

20d. INJURY OCCURRED: While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town): (County): AACO (State): MD

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: [signature] M D

EXAMINER'S NAME (Type): E. Linhardt

Address (Street, city, town, or county):

DATE SIGNED: 3/5/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-7-1961

22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Memorial

22d. LOCATION (City, town, or country): Annapolis (State): Md.

23. FUNERAL DIRECTOR: John M. Gaylo Sons ADDRESS: Annapolis Md.

24a. REC'D BY REGISTRAR DATE: MAR 7 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

Nov

2 (331) x 4

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2617 — 02597

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 2mo. 15 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 806 Sharp Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐ ?

3. NAME OF DECEASED (Type or print): First: Clarence; Middle: ; Last: Dixon

4. DATE OF DEATH: Month: 3; Day: 27; Year: 1961

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: August 20, 1904

9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver

10b. KIND OF BUSINESS OR INDUSTRY: ----------

11. BIRTHPLACE (County & State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles Dixon

14. MOTHER'S MAIDEN NAME: Georgianna ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT Address: Hospital Records

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cachexia — INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Cancer Metastases in Brain

DUE TO (c): Bronchogenic Carcinoma

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): ----------

20c. TIME OF INJURY: Month, Day, Year; Hour a.m. p.m. ---- 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ----------

20f. (City or town) (County) (State): ----------

21. **I certify** that (I) (this hospital) attended the deceased from 1/12 19 61 to 3/27 19 61, that (I) (we) last saw the deceased alive on 3/27 19 61, and that death occured at 8:20 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Hildegard Heard Reimsman M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3/28/61

22c. PHYSICIAN'S NAME (Type): Hildegard Heard Reimsman, M. D.

22d. ADDRESS: Crownsville State Hospital, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town or county) (State)

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25a. REC'D BY REGISTRAR DATE: APR 5 '61

25b. REGISTRAR'S SIGNATURE: Clifton L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2618

CERTIFICATE OF DEATH

02598

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 15 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - Millersville
d. STREET ADDRESS: Indian Landing Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Walter — Middle: E. — Last: DOVE

4. DATE OF DEATH: Month: March — Day: 22 — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 13, 1894

9. AGE (In years last birthday): 66 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Entomologist

11. BIRTHPLACE (County & State, or foreign country): Mississippi

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Thomas Dove

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): WW I

16. SOCIAL SECURITY NO.: 578-38-2318

17. INFORMANT: Mrs. Walter Dove — Address: 2 C + D

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchogenic Carcinoma
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH: 4-5 Months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) ~~(this hospital)~~ attended the deceased from Mar. 7, 1961 to Mar. 22, 1961 that (I) ~~(he)~~ last saw the deceased alive on Mar. 22, 1961, and that death occured at 2:40 P.M, from the causes and on the date stated above.

22a. SIGNATURE: Gerard Church M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Gerard Church

22d. ADDRESS: 121 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 3-25-61 — 23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cem — 23d. LOCATION (City, town or county) (State): Washington, D.C.

24. FUNERAL DIRECTOR'S SIGNATURE: Robert S. Gannaway — ADDRESS: Severna Park, Md.

25a. REC'D BY REGISTRAR — DATE MAR 28 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2619 02599

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort George G. Meade
   c. LENGTH OF STAY IN 1b: 6 yrs
   d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: United States Army Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hanover
   d. STREET ADDRESS: 12 Mulberry Rd
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: FRANCIS — Middle: — Last: EGAN

4. DATE OF DEATH: Month: MARCH — Day: 27 — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: Cau

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: March 17. 1892

9. AGE (In years last birthday): 69 yrs
   IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: US Army

11. BIRTHPLACE (State or foreign country): Mass.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Daughter) Patricia Knefel — Address: Same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Renal Failure — INTERVAL BETWEEN ONSET AND DEATH: One day

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Congestive heart failure & pneumonia — Three days

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cirrhosis and severe malnutrition

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 24 March, 1961 to 27 March, 1961, that (I) (~~he~~) last saw the deceased alive on 27 March 1961, and that death occurred at 3:15 PM from the causes and on the date stated above.

22a. SIGNATURE: Nathaniel S Beard M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 27 Mar 61

22c. PHYSICIAN'S NAME (Type): NATHANIEL S. BEARD, Capt., M.C.

22d. ADDRESS: USA Hosp Ft Geo G. Meade, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: March 30-61 — 23c. NAME OF CEMETERY OR CREMATORY: Arlington Natl — 23d. LOCATION (City, town or county): Arlington Va (State):

24. FUNERAL DIRECTOR'S SIGNATURE: Bernard A Funk — ADDRESS: Glen Burnie Md

25a. RECD BY REGISTRAR DATE: MAR 30 '61

25b. REGISTRAR'S SIGNATURE: Clarence L. Kraus

VR A1S (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2620

CERTIFICATE OF DEATH

Reg. Dist. No. 02600

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b: 52 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. NAVAL HOSPITAL, ANNAPOLIS, MARYLAND

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SHADY SIDE
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Lois — Middle: (n) — Last: EICHLER

4. DATE OF DEATH: Month: MARCH — Day: 14 — Year: 19 61

5. SEX: FEMALE

6. COLOR OR RACE: CAUC.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-26-1908

9. AGE (In years last birthday): 52 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: RIVES, French Davis

14. MOTHER'S MAIDEN NAME: ATERHOLT, Inez (n)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: (Husband) Herman T. EICHLER, Shady Side, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac Asystole — INTERVAL BETWEEN ONSET AND DEATH: None

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): Acute Myocardial Infarction — 8 Weeks

DUE TO

(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 21 January, 19 61, to 14 March, 19 61, that I last saw the deceased alive on 14 March, 19 61, and that death occurred at 8:20A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Sylvan Busch Jr. M.D. — ADDRESS (Street, city or town, state): U.S.Naval Hospital, Annapolis, Maryland — DATE SIGNED: 14 March 1961

PHYSICIAN'S NAME (Type): Sylvan BUSCH, LT MC USNR

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 3-17-61

22c. NAME OF CEMETERY OR CREMATORY: Oakwood Cem.

22d. LOCATION (City, town, or county) (State): Statesville N.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Lee FUNERAL Home — ADDRESS: Wash, D.C.

24a. REC'D BY REGISTRAR — DATE: MAR 16 '61

24b. REGISTRAR'S SIGNATURE: Clinton S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
1 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G283 3/27/61 jwk

CERTIFICATE OF DEATH

Reg. Dist. No. 0260i

2621

1. PLACE OF DEATH a. COUNTY Gaco Md MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Glen Burnie Md
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Md b. COUNTY Gaco
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie Md
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First KENNETH Middle Last FARBER
4. DATE OF DEATH Month 3 Day 20 Year 1961
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH ~~Dec~~ Nov 26 1908
9. AGE (In years last birthday) 52 yrs
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY Depart Store
11. BIRTHPLACE (State or foreign country) Ohio
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME James B Farber
14. MOTHER'S MAIDEN NAME Mary Minard
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
INFORMANT Richard D. Farber Address 609 Thaxton Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastric Hemorrhage
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from October, 1957, to March, 1961, that I last saw the deceased alive on March 13, 1961, and that death occurred at 2:30 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE R. MacDonald Md M.D. ADDRESS (Street, city or town, state) 204 Crain Hwy So DATE SIGNED 3-20 61
PHYSICIAN'S NAME (Type) C. R. MacDONALD M.D. Glen Burnie Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF March 22-61
22c. NAME OF CEMETERY OR CREMATORY Glen Haven
22d. LOCATION (City, town, or county) (State) Ritchie Hwy Glen Burnie Md

23. FUNERAL DIRECTOR'S SIGNATURE Bernard A Fink ADDRESS Glen Burnie Md
24a. REC'D BY REGISTRAR DATE MAR 22 '61
24b. REGISTRAR'S SIGNATURE Conrad L. Hauck

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2622

CERTIFICATE OF DEATH

02602

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: A.A. GENERAL HOSPT.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: A. A. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
d. STREET ADDRESS: 714 SPRINGDALE AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

M

3. NAME OF DECEASED (Type or print): First JOHN Middle C. Last FERGUSON
4. DATE OF DEATH: Month MAR Day 25 Year 1961
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: NOV 15 1909
9. AGE (In years last birthday): 51 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman Mech PWD
10b. KIND OF BUSINESS OR INDUSTRY: U.S Naval Academy
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.

I

13. FATHER'S NAME: CHARLES FERGUSON
14. MOTHER'S MAIDEN NAME: MARGARE KLEIN
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: EMMA R. FERGUSON #2 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH: Sudden

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from JAN. 60, 19__, to 3-25, 1961, that (I) (we) last saw the deceased alive on 3-25 1961, and that death occurred at 11:30 A.M., from the causes and on the date stated above

22a. SIGNATURE: C. Linthicum M.D
ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 3/26/61
22c. PHYSICIAN'S NAME (Type): E. LINTHICUM
22d. ADDRESS: Annapolis Md

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE THEREOF: 3/29/61
23c. NAME OF CEMETERY OR CREMATORY: GRANITE PRES. CEM.
23d. LOCATION (City, town, or county) (State): GRANITE MD.

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: JOHN M. TAYLOR · SONS ANNAPOLIS MD
25a. REC'D BY REGISTRAR DATE: MAR 28 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

Item 18 Film 286 5- 1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2623 02603

1 PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort George G. Meade
c. LENGTH OF STAY IN 1b: 5 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Army Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Fort George G. Meade~~ X
d. STREET ADDRESS: Quarters # 7201-D
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: JANET — Middle: ALICE — Last: FINCHER

4. DATE OF DEATH: Month: MARCH — Day: 13 — Year: 19 61

5. SEX: Female — **6. COLOR OR RACE**: Non /Cau — **7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ N/A **DIVORCED** ☐

8 DATE OF BIRTH: 24 Oct 1960

9 AGE (In years last birthday) yrs. — IF UNDER 1 YEAR: Months 4, Days 20 — IF UNDER 24 HRS: Hours, Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): -
10b. KIND OF BUSINESS OR INDUSTRY: -
11 BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James A Fincher
14. MOTHER'S MAIDEN NAME: Mutsuko Kaminae

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): - (If yes, give war or dates of service): -
16. SOCIAL SECURITY NO: -
17. INFORMANT (Father) Address: Qtrs 7201-D Ft Geo G. Meade, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cause unknown R/Broncho pneumonia, Bilateral,
DUE TO (b): Etiology Klebsiella Aerobacter Group. Pulmonary congestion and edema, bilateral, marked.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 491X

INTERVAL BETWEEN ONSET AND DEATH: Unk

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that ~~I~~ (this hospital) ~~attended~~ examined the deceased from ____ 19__, to 13 March 19 61, ~~last saw the deceased alive on~~ ____ 19__, and that death occurred at 12:30 from the causes and on the date stated above

22a. SIGNATURE: Herman S Robinson M.D.
ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED: 13 Mar 61
22c PHYSICIAN'S NAME (Type): SHERMAN S. ROBINSON, Capt., M.C.
22d. ADDRESS: US Army Hosp Ft Geo G. Meade, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: March 16, 1961
23c NAME OF CEMETERY OR CREMATORY: Balt. National
23d LOCATION (City, town, or county) (State): Baltimore Md.

24 FUNERAL DIRECTOR'S SIGNATURE: DeWitt Donaldson
ADDRESS: Laurel, Md
25a. REC'D BY REGISTRAR DATE: MAR 2 3 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2624 02604

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Linthicum Heights
c. LENGTH OF STAY IN 1b: 38 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 500 Cleveland Road

2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Linthicum Heights
d. STREET ADDRESS: 1500 Cleveland Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First Arthur — Middle W. — Last Fletcher

4. DATE OF DEATH: Month March — Day 17 — Year 1961

5 SEX	6. COLOR OR RACE	7 MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8 DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min
Male	White	☐ / ☐ / ☐ / ☐	March 19-1883	77 yrs		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ticket Agent (Ret)	Balto & Ohio R.R.	Rockville, Maryland	U.S.A.

13. FATHER'S NAME: Arthur H. Fletcher
14. MOTHER'S MAIDEN NAME: Julia M. Wadsworth

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 220-09-6921
17 INFORMANT: Mrs. Clara M. Fletcher — Address: Same as # 2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardio-Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 5 years

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p m — Month, Day, Year 19	20d INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. **I certify** that (I) (this hospital) attended the deceased from ____ 19 50, to March 17, 1961, that (I) (we) last saw the deceased alive on March 17 19 61, and that death occurred at 2 9 A M, from the causes and on the date stated above.

22a. SIGNATURE	ATTENDING PHYS / MED. DIRECTOR / STAFF PHYS	22b. DATE SIGNED
James S Billingsley M.D	☒ / ☐ / ☐	March 18. 1961

22c. PHYSICIAN'S NAME (Type)	22d ADDRESS
James S Billingsley	10 S Central Ave Glen Burnie Md.

23a BURIAL, CREMAT ON, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City, town, or county) (State)
Burial	3-20-1961	Meadowridge Memorial Park	Howard Co. Maryland

24 FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	25a. REC'D BY REGISTRAR	25b REGISTRAR'S SIGNATURE
Richard V. Singleton	Glen Burnie, Maryland	DATE MAR 21 '61	Arthur S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2625 02605

1. PLACE OF DEATH
a. COUNTY: AA — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riviera Beach
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 8489 Arbutus Rd

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Baltimore~~ Riviera Beach
d. STREET ADDRESS: 8489 Arbutus Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Thomas Middle C. Last Ford

4. DATE OF DEATH: Month 3 Day 21 Year 1961

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-19-02
9. AGE (In years last birthday): 59 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Emil Ford
14. MOTHER'S MAIDEN NAME: Lucietta Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO
(If yes, give war or dates of service): -
16. SOCIAL SECURITY NO: -
17. INFORMANT: Family — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of the right lung — INTERVAL BETWEEN ONSET AND DEATH: 18 months
DUE TO
163X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Generalized hypertrophic osteoarthritis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from July 20 1960 to Mar. 21 1961, that (I) (we) last saw the deceased alive on Mar. 19 1961, and that death occurred at 1:50 A.M. from the causes and on the date stated above.

22a. SIGNATURE: R. M. McLaughlin M.D
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 3/21/61
22c. PHYSICIAN'S NAME (Type): R. M. McLaughlin
22d. ADDRESS: 3108 Mountain Rd. Pasadena, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): B
23b. DATE THEREOF: 3-24-61
23c. NAME OF CEMETERY OR CREMATORY: Meadowridge Cem.
23d. LOCATION (City, town, or county) (State): Elkridge MD

24. FUNERAL DIRECTOR'S SIGNATURE: McCully Funeral Home
ADDRESS: 130 E Fort Ave
25a. REC'D BY REGISTRAR DATE: MAR 23 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2627 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02607

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millersville
c. LENGTH OF STAY IN 1b: MARYLAND 6 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Box 60 Route 3

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Same
b. COUNTY: Same
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Same
d. STREET ADDRESS: Same
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Gilbert Middle: Gene Last: Gartelman

4. DATE OF DEATH: Month: March Day: 27th. Year: 1961

5. SEX: M.

6. COLOR OR RACE: W.

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9/8/60

9. AGE (In years last birthday) yrs. IF UNDER 1 YEAR Months: 6 Days: 19 IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Gilbert James Gartelman

14. MOTHER'S MAIDEN NAME: Doris Marie Frazier

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: The parents. Address:

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute pulmonary infection. — INTERVAL BETWEEN ONSET AND DEATH: Few hours.

5210

DUE TO (b):

Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gustave H. Faubert M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 3/27/61

EXAMINER'S NAME (Type): Gustave H. Faubert, M.D.

Address (Street, city, town, or county): Glen Burnie, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 29th March '61

22c. NAME OF CEMETERY OR CREMATORY: Glen Haven Cem.

22d. LOCATION (City, town, or country) (State): Glen Burnie, Md.

23. FUNERAL DIRECTOR: R F Singleton

ADDRESS: Glen Burnie, Md.

24a. REC'D BY REG. STRAR DATE: MAR 28 '61

24b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5. A15ME
5M. 7159

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2626 **CERTIFICATE OF DEATH** 02606

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1 PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland — b. COUNTY: Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hanover	c. LENGTH OF STAY IN 1b: Life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hanover	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Box 12 Ridge Road		d. STREET ADDRESS: Box 12 Ridge Road	e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Emma	R.	German	March	3	1961

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min.
Female	White	WIDOWED [X]	2 August 1880	80 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	own Home	Washington D.C.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George L. Sherwood	Emmit R. Love

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address	
No	None	Mr. Joeseph L. German Jr.	Same as # 2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chr Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 6 mo

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (b) Generalized Arteriosclerosis — 2 yrs

DUE TO (c) Inflammatory Fever — 5 days

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work [ ] Not while at work [ ]	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21 **I certify** that (I) (this hospital) attended the deceased from Sept. 19[illegible] to Mch 3 1961, that (I) (~~no~~) last saw the deceased alive on Mch 1 1961, and that death occurred at 5:0 M, from the causes and on the date stated above

22a. SIGNATURE	ATTENDING PHYS [X] / MED. DIRECTOR [ ] / STAFF PHYS [ ]	22b. DATE SIGNED
B B Brumbaugh M. D.		3/3/61

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
B B Brumbaugh	560 Mearns St Elkridge 27 Md

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Burial	3-Mar. 1961	Meadowridge Mem. Park	Howard Co. Maryland

24. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
A. V. Bumgardner	Glen Burnie, Md.	MAR 6 '61	Arthur E. Hance

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2628

CERTIFICATE OF DEATH

02608

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Item 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 2 yrs. 9 mos. 9 days
d. NAME OF HOSP.TAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Newburg
d. STREET ADDRESS: Unknown
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Ruby; Middle: Elizabeth; Last: Green

4. DATE OF DEATH: Month: 3; Day: 20; Year: 1961

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7/28/27

9. AGE (In years last birthday): 33 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

215-26-0690

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? Maryland U.S.A.

13. FATHER'S NAME: Frank Green

14. MOTHER'S MAIDEN NAME: Rebecca ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Hospital Records
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Torula Meningitis 134.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): 134.1

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour ——— a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1/15 ....., 1958 to 3/20 ....., 1961, that (I) (we) last saw the deceased alive on 3/20/ .....1961..., and that death occured at 11:30 p.m. from the causes and on the date stated above.

22a. SIGNATURE: Hildegard Heard Reissmann M.D.

22b. DATE SIGNED: 3/21/61

22c. PHYSICIAN'S NAME (Type): Hildegard H. Reissmann, M.D.

ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22d. ADDRESS: Crownsville State Hospital, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/24/61

23c. NAME OF CEMETERY OR CREMATORY: Shiloh Methodist

23d. LOCATION (City, town or county) (State): Shiloh, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Rockhold Funeral Home

ADDRESS: Lusby, Md.

25a. REC'D BY REGISTRAR DATE: APR 7 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2629 **CERTIFICATE OF DEATH** 02609

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

I

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 21 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - Annapolis
d. STREET ADDRESS: Severn Forest Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mabel; Middle: ; Last: GRIFFIN

4. DATE OF DEATH: Month: March; Day: 6; Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Feb. 3, 1877

9. AGE (In years last birthday): 84 yrs. IF UNDER 1 YEAR: Months: ; Days: IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): New Hampshire

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: R. FOREST TOWLE

14. MOTHER'S MAIDEN NAME: ELMA GORDON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: George Feldmann — Address: Severn Forest. Annapolis Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Artery thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 wks.
DUE TO (b):
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bronchopneumonia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~[illegible]~~) attended the deceased from Feb. 13, 19 61 to Mar. 6, 19 61, that (I) (~~saw~~) last saw the deceased alive on Mar. 6, 1961, and that death occured at 3:40 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Richard N. Peeler M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3/6/61

22c. PHYSICIAN'S NAME (Type): Richard N. Peeler

22d. ADDRESS: 121 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Mar 10-61

23c. NAME OF CEMETERY OR CREMATORY: North Danvall Cemt

23d. LOCATION (City, town or county) (State): Danvalle N. H.

24. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons

ADDRESS: Annapolis Md.

25a. REC'D BY REGISTRAR DATE: MAR 10 '61

25b. REGISTRAR'S SIGNATURE: O. Howe S. Howe

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2630

CERTIFICATE OF DEATH

02610

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
   a. COUNTY: a a Co - | MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): annapolis | c. LENGTH OF STAY IN 1b: 6 hours
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: maryland | b. COUNTY: a a Co.
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Dale
   d. STREET ADDRESS: Highview Nutwell A.A. Co. | e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Frederick | Middle: | Last: Guest

4. **DATE OF DEATH**: Month: March | Day: 25 | Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct 8, 1891

9. AGE (In years last birthday): 69 yrs | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Service Sta.

10b. KIND OF BUSINESS OR INDUSTRY: Own. Business

11. BIRTHPLACE (County & State, or foreign country): Sommerville N.J.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Paul Guest

14. MOTHER'S MAIDEN NAME: Martha Lehman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No.

16. SOCIAL SECURITY NO: 218-32-2321

17. INFORMANT: Nellie Guest. | Address: Highview Nutwell

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): acute pulmonary edema
DUE TO (b): coronary artery disease
DUE TO (c): Bleeding duodenal ulcer.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 541.0

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1.a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. | Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State)

21. **I certify** that (I) (this hospital) attended the deceased from March 25, 1961 to March 25, 1961, that (I) (we) last saw the deceased alive on March 25 1961, and that death occured at 3:40 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Emily H. Wilson M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3-26-61

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS: Lothian Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE THEREOF: March 30, 1961 | 23c. NAME OF CEMETERY OR CREMATORY: Moreland | 23d. LOCATION (City, town or county): Belair | (State): Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Lassahn Funeral Home | ADDRESS: 7401 Belair Road #6.

25a. REC'D BY REGISTRAR DATE: APR 3 '61 | 25b. REGISTRAR'S SIGNATURE: Arthur E. Hance

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2631

CERTIFICATE OF DEATH

Reg. Dist. No. 02611

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 25 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 19 Morris Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 19 Morris Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Florence — Middle: Warren — Last: Hall

4. DATE OF DEATH: Month: March — Day: 29 — Year: 19 61

5. SEX: Female
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 27-1870
9. AGE (In years last birthday): 90 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY: **********
11. BIRTHPLACE (State or foreign country): Annapolis, Maryland
12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George Warren
14. MOTHER'S MAIDEN NAME: Elizabeth ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
INFORMANT: Margaret Grooms — Address: 19 Morris St. Anna. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cystoid calcified Hypertensive Cardio
DUE TO (b): Vascular Disease Grade III 9 Yrs
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
443X
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 15, 1957 to 3/29/61, that I last saw the deceased alive on 3/29, 1961, and that death occurred at 6:45 PM, from the causes and on the date stated above.
ACTUAL SIGNATURE: R.L. Richardson M.D
ADDRESS (Street, city or town, state): 110 Clay Street - Annapolis, Md.
DATE SIGNED: 3/29/61
PHYSICIAN'S NAME (Type): R.L.Richardson

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Apr. 2-61
22c. NAME OF CEMETERY OR CREMATORY: Asbury
22d. LOCATION (City, town, or county) (State): Annapolis, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: C.E.HICKS
ADDRESS: 111 Annapolis, Maryland
24a. REC'D BY REGISTRAR DATE: APR 4 '61
24b REGISTRAR'S SIGNATURE: C. Lind L. Wade

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2632

CERTIFICATE OF DEATH

02612

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN MARYLAND: 1 yr 2 mos. 20 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 909 Shields Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elizabeth (Hairston) Middle: Harrison Last:

4. DATE OF DEATH: Month: 3 Day: 12 Year: 1961

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1904

9. AGE (In years last birthday): 56 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Unknown Address: Hospital Records

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypostatic Pneumonia
DUE TO (b): Hypertensive Cardiovascular Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a): Chronic Brain Syndrome asso. w. Cerebral Arteriosclerosis.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour—a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/28/ ...., 19.57 to .3/12/....., 1961, that (I) (we) last saw the deceased alive on .....3/12/ .... .1961 , and that death occured at 12:45 p.m. from the causes and on the date stated above.

22a. SIGNATURE: Hildegard Heard Reissmann M.D.

22b. DATE SIGNED: 3/13/61

22c. PHYSICIAN'S NAME (Type): Hildegard H. Reissmann, M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22d. ADDRESS: Crownsville State Hospital, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/15/61

23c. NAME OF CEMETERY OR CREMATORY: Baltimore National

23d. LOCATION (City, town or county) (State): Baltimore Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Maitland K Yeth

ADDRESS: 916 Pennsylvania ave

25a. REC'D BY REGISTRAR DATE: MAR 16 '61

25b REGISTRAR'S SIGNATURE: Arthur L. Harris

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2633

CERTIFICATE OF DEATH

Reg. Dist. No. 02613

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 35 Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 1946 West Street

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 1946 West Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Daisy Middle Harried or Harrod Last
4. DATE OF DEATH: Month March Day 6 Year 1961

5. SEX: Female
6. COLOR OR RACE: Colored
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 10- 1897
9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY: **********
11. BIRTHPLACE (State or foreign country): A.A.Co. Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lewis Butler
14. MOTHER'S MAIDEN NAME: Martha Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service,)
16 SOCIAL SECURITY NO.: 215-16-9404
INFORMANT Address: Milburn Harried - 1946 West St. Anna. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c)]
PART I. DEATH WAS CAUSED BY,
IMMEDIATE CAUSE (a): Cerebral Hemorrhage
DUE TO (b): Arterio sclerotic (Hypertensive disease)
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 5 Weeks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year: Hour a. m. / p. m. 19
20d. INJURY OCCURRED White at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 6, 1961, to March 6, 1961, that I last saw the deceased alive on March 6, 1961, and that death occurred at 1:30 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: R L Richardson MD
ADDRESS (Street, city or town, state): 110 - Clay St
DATE SIGNED: 3/9/61
PHYSICIAN'S NAME (Type): R.L.Richardson
110 Clay St. Annapolis, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-9-61
22c NAME OF CEMETERY OR CREMATORY: Fowlers Chapel
22d. LOCATION (City, town, or county) (State): Annapolis, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: C.E.Hicks III
ADDRESS: Annapolis, Maryland
24a. REC'D BY REGISTRAR DATE: MAR 13 '61
24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2634

CERTIFICATE OF DEATH

02614

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Odenton
c. LENGTH OF STAY IN 1b: 10 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Conley Bldg. - Box 310X

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Odenton
d. STREET ADDRESS: Conley Bldg. - Box 310X
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: C. — Last: Hart

4. DATE OF DEATH: Month: March — Day: 19 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 11th June 1887

9. AGE (In years last birthday): 73 yrs

IF UNDER 1 YEAR / IF UNDER 24 HRS — Months / Days / Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework (ret.)

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Port Perry, Pennsy.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: (Unknown) Slane

14. MOTHER'S MAIDEN NAME: Catherine Coyle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No — (If yes, give war or dates of service): ———

16. SOCIAL SECURITY NO: None

17. INFORMANT: Mrs. Louise Zomp — Address: June Drive, Odenton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral [illegible] — INTERVAL BETWEEN ONSET AND DEATH

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Hypertensive [illegible]

DUE TO (c): Digene [illegible]

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-24 19 59 to 6/24 19 60 that (I) (we) last saw the deceased alive on 6/24 1960, and that death occurred at [illegible] m. from the causes and on the date stated above.

22a. SIGNATURE: [illegible] M.D

ATTENDING PHYS. ☑ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 7/28/61

22c. PHYSICIAN'S NAME (Type): [illegible]

22d. ADDRESS: P.O. [illegible] Odenton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 23rd March '61

23c. NAME OF CEMETERY OR CREMATORY: Braddock Catholic Cem.

23d. LOCATION (City, town, or county) (State): Braddock Pennsy.

24. FUNERAL DIRECTOR'S SIGNATURE: R. V. Singleton — ADDRESS: Glen Burnie, Maryland

25a. REC'D BY REGISTRAR DATE: MAR 21 '61

25b. REGISTRAR'S SIGNATURE: Clifton L. Evans

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2635

CERTIFICATE OF DEATH

02615

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: ✓

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort George G. Meade

c. LENGTH OF STAY IN 1b: -

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Army Hospital

d. STREET ADDRESS: 604 S Rappalla St

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First - Middle - Last: HAYES

4. DATE OF DEATH: Month: MARCH Day: 3 Year: 19 61

5. SEX: Male

6. COLOR OR RACE: Cau

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ N/A DIVORCED ☐

8. DATE OF BIRTH: 2 March 1961

9. AGE (In years last birthday) yrs

IF UNDER 1 YEAR: Months - Days - IF UNDER 24 HRS: Hours 6 Min. 58

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): -

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Robert T Hayes

14. MOTHER'S MAIDEN NAME: Janice L. Crapser

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): - (If yes, give war or dates of service): -

16. SOCIAL SECURITY NO.: -

17. INFORMANT Address: (Father) 604 S. Rappalla St Balto, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiorespiratory failure — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b): Prematurity

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) attended the deceased from 6:30 PM 2 Mar 61 to 1:28 A, 19___, that (I) last saw the deceased alive on 3 Mar 19 61, and that death occurred at ___ M, from the causes and on the date stated above.

22a. SIGNATURE: George Norman Schultz M.D.

ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☒

22b. DATE SIGNED: 3 Mar 61

22c. PHYSICIAN'S NAME (Type): GEORGE N. SCHULTZ, M.D.

22d. ADDRESS: USA Hosp Ft Geo G. Meade, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): ✓

23b. DATE THEREOF: 3 MAR 61

23c. NAME OF CEMETERY OR CREMATORY: USA Hosp

23d. LOCATION (City, town, or county) (State): Ft Geo G Meade, Md

24. FUNERAL DIRECTOR'S SIGNATURE: Shirley J. Linden 2Lt MSC

ADDRESS

25a. RECD BY REGISTRAR DATE: MAR 7 61

25b REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2636

CERTIFICATE OF DEATH

02616

M

1. **PLACE OF DEATH**
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 8 Hill St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alice; Middle: Irene; Last: HILPRECHT

4. DATE OF DEATH: Month: March; Day: 22; Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 21, 1906

9. AGE (In years last birthday): 55 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

I

13. FATHER'S NAME: John H. Vinson

14. MOTHER'S MAIDEN NAME: Claraissa V Hirshburger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wars or dates of service):

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Karl Hilprecht — Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiovascular Collapse — INTERVAL BETWEEN ONSET AND DEATH: 4-5 hrs.

DUE TO (b): Cachexia — 6 wks.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Carcinomatosis - Stomach 3 mos.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (Xxx hospital) attended the deceased from Jan. 25, 19 61 to Mar. 22, 19 61, that (I) (XX) last saw the deceased alive on Mar. 22, 19 61, and that death occured at 7:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Stuart M. Christhilf, Jr. M.D

ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3/24/61

22c. PHYSICIAN'S NAME (Type): Stuart M. Christhilf, Jr., M.D.

22d. ADDRESS: 69 Franklin St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3-25-1961

23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Memorial

23d. LOCATION (City, town or county): Annapolis (State): Md

24 FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons ADDRESS: Annapolis Md.

25a. REC'D BY REGISTRAR DATE: MAR 27 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2637 Item 7 Film, 263, 3/27/61 1wk

02617

1. **PLACE OF DEATH**
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 20 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - Millersville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: RICHARD Middle: Austin Last: HUMRICKHOUSE

4. **DATE OF DEATH**: Month: March Day: 19 Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: August 5, 1877

9. AGE (In years last birthday): 83 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plant Supervisor

10b. KIND OF BUSINESS OR INDUSTRY: Battery Plant

11. BIRTHPLACE (County & State, or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: SAMUEL P. HUMRICKHOUSE

14. MOTHER'S MAIDEN NAME: WILHELMINA WARNER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of serv'ce)

16. SOCIAL SECURITY NO.

17. INFORMANT: Address: EDNA S. KEEN 315 COVE RD. RIVA, MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TOXEMIA — INTERVAL BETWEEN ONSET AND DEATH: 3 wks

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) Gangrene, dist. lower extremity, left — 2 mo

DUE TO

(c) Arteriosclerotic cardiovascular disease — 10 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) attended the deceased from Feb 27, 1961, to Mar 19, 1961, that (I) (~~was~~) last saw the deceased alive on Mar 19, 1961, and that death occured at 5:20 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Merton T Waite, M.D.

22b. DATE SIGNED: 3-19-61

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): Merton T. Waite

22d ADDRESS: 121 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 3-23-61

23c. NAME OF CEMETERY OR CREMATORY: W. LAUREL HILL

23d. LOCATION (City, town or county) (State): PHILA. PA.

24 FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor & Sons ADDRESS: Annapolis, Md.

25a. REC'D BY REGISTRAR DATE: MAR 22 '61

25b. REGISTRAR'S SIGNATURE: Clifton S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2638 Reg. Dist. No. 02618

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 25 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 47 Northwest Street

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 47 Northwest Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Irven — Middle: Thomas — Last: James

4. DATE OF DEATH: Month: March — Day: 10 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: Apr. 9-1894

9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months: ___ Days: ___
IF UNDER 24 HRS.: Hours: ___ Min.: ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer - U.S.Naval Academy - Retired

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Annapolis, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William T. James

14. MOTHER'S MAIDEN NAME: Carrie S. Bias

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes. (If yes, give war or dates of service): W.W.I

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT — Address: Richard I. James - 47 Northwest St. Anna. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Arrest
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: Instant

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: E. Linhardt M.D.
EXAMINER'S NAME (Type): E. LINHARDT.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 3/21/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-14-61
22c. NAME OF CEMETERY OR CREMATORY: U.S.National
22d. LOCATION (City, town, or county) (State): Annapolis, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: C.E.Hicks III - Annapolis, Maryland

24a. REC'D BY REGISTRAR — DATE: MAR 21 '61

24b. REGISTRAR'S SIGNATURE: Carlton L. Hines

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2639 — 02619

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbons. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
   c. LENGTH OF STAY IN 1b: 49 days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Plaza Manor Nursing Home

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
   a. STATE: Maryland — b. COUNTY: Ann Arundel
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Odenton
   d. STREET ADDRESS: Rt.1 Box 177 D
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Emma — Middle: — Last: Johnson

4. **DATE OF DEATH**: Month: March — Day: 9 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 1, 1889

9. AGE (In years last birthday): 71 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (County & State, or foreign country): Gloucester, New York

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Alice Browne A.A. Co. D.P.W.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
- IMMEDIATE CAUSE (a): Hypertensive cardiovascular disease
- DUE TO (b):
- DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: ? yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from January 19, 19 61 to March 9, 19 61 that (I) (~~we~~) last saw the deceased alive on March 4, 1961, and that death occured at 9:15 A.M. from the causes and on the date stated above.

22a. SIGNATURE: James M. Pair M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3-9-1961

22c. PHYSICIAN'S NAME (Type): James M. Pair, M.D.

22d. ADDRESS: 400 N. Carrollton Avenue Balto. 23, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): B

23b. DATE THEREOF: 3-11-61

23c. NAME OF CEMETERY OR CREMATORY: Glen Haven

23d. LOCATION (City, town or county) (State): Glen Burnie, Md.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Mudd Funeral Home 153 East St.

25a. REC'D BY REGISTRAR — DATE: MAR 13 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Krause

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

~~2640~~ 02620

1 M I

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 9 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - Annapolis
d. STREET ADDRESS: Rt-2, Box-620A
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Mary		JOHNSON	March	15	19 61

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	Negro		January 2, 1902	59 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Allen Champ
14. MOTHER'S MAIDEN NAME: Allie Jones
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No (If yes give wars or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Granville Redding Address: Margaret Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 193.0
DUE TO (b): Glioma of left Parietal Lobe of the Cerebrum
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 10 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) ~~(Did not)~~ attended the deceased from Mar. 6, ..., 19 61 to Mar. 14, ..., 19 61 that (I) ~~(Did not)~~ last saw the deceased alive on Mar. 14, ... 19 61, and that death occured at 1:00 A.M., from the causes and on the date stated above.

22a. SIGNATURE: R. L. Richardson M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/17/61
22c. PHYSICIAN'S NAME (Type): R. L. Richardson
22d. ADDRESS: 110 Clay St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-18-1961
23c. NAME OF CEMETERY OR CREMATORY: Broadneck
23d. LOCATION (City, town or county) (State): Margaret Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Wallace Rose # Annap Md.
ADDRESS:

25a. REC'D BY REGISTRAR DATE: MAR 20 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2641

CERTIFICATE OF DEATH

02621

Item 2c, Film G285 3/29/61 jrk

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH — a. COUNTY: Anne Arundel — b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville — c. LENGTH OF STAY IN 1b: 40 yrs — d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) — a. STATE: Md — b. COUNTY: Calvert ✓ — c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Golftown — d. STREET ADDRESS: R. 1 X — e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Robert — Middle: C. — Last: Johnson

4. DATE OF DEATH: Month: 3 — Day: 17 — Year: 1961

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☑ **DIVORCED** ☐

8. DATE OF BIRTH: 2-3-83

9. AGE (In years last birthday): 78 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Elizah Johnson

14. MOTHER'S MAIDEN NAME: Minnie Keys

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOC. SEC. NO.:

17. INFORMANT — Address: Emmitsburg, Md

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): hypostatic pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO (b): arteriosclerotic cardiovascular disease many yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): chronic brain syndrome

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED: While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) — (County) — (State)

21. I certify that (I) (this hospital) attended the deceased from 3-23-, 19 61 to 3/17, 19 61, that (I) (we) last saw the deceased alive on 3/17, 19 61, and that death occured at 4:20 AM, from the causes and on the date stated above.

22a. SIGNATURE: Richard Heard Reisman M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 3/17/61

22c. PHYSICIAN'S NAME (Type): #HEARD-REISMAN — 22d. ADDRESS: CROWNSVILLE, MD

23a. (BURIAL) CREMATION, REMOVAL (Specify) — 23b. DATE THEREOF: 3-21-61 — 23c. NAME OF CEMETERY OR CREMATORY: St. Johns — 23d. LOCATION (City, town or county) (State): Ferndale, Anne Arundel

24. FUNERAL DIRECTOR'S SIGNATURE: D. E. Sweeney — ADDRESS: Ft. Fredericka — 25a. RECD BY REGISTRAR DATE: MAR 23 '61 — 25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2642

CERTIFICATE OF DEATH

02622

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gambrills
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rte. 1, Box 600

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE Md. b. COUNTY AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Gambrills
d. STREET ADDRESS Rte. 1, Box 600
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Henry Middle A. Last Kaufmann.
4. DATE OF DEATH Month March Day 19 Year 19 61

5. SEX M
6. COLOR OR RACE W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH June 12, 1884
9. AGE (In years last birthday) 76 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter
10b. KIND OF BUSINESS OR INDUSTRY Retired
11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Adam Kaufmann
14. MOTHER'S MAIDEN NAME Mary Stupe

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO 220-05-7434
17. INFORMANT Address Mrs Katherine Kaufmann, same as 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure - decompensated
DUE TO (b) Sclerotic Cardiovascular disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH a few

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Ca. Bladder & metastases to lung. Histoplasmosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from Jan 1961, to March 17 1961, that (I) (we) last saw the deceased alive on March 11 1961, and that death occurred at 7 a.m. M, from the causes and on the date stated above.

22a SIGNATURE Febus Grunberg, M.D. M D
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b DATE SIGNED 3/20/61
22c PHYSICIAN'S NAME (Type) Febus Grunberg, M.D.
22d. ADDRESS Odenton, Md.

23a BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 3/22/61
23c NAME OF CEMETERY OR CREMATORY Loudon Park Cem.
23d. LOCATION (City, town, or county) (State) Baltimore, Md.

24 FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley
ADDRESS Glen Burnie, Md
25a. REC'D BY REGISTRAR DATE MAR 21 '61
25b REGISTRAR'S SIGNATURE Carlton S. Knowles

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2643

CERTIFICATE OF DEATH

Reg. Dist. No. 02623

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General

2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Churchton, Md.
d. STREET ADDRESS: Franklin Manor
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Clorence Middle S. Last Keller
4. DATE OF DEATH: Month March Day 14 Year 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 9/10/1874
9. AGE (In years last birthday): 86 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): (ret'd) Musician
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): York, Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Jacob F.Keller
14. MOTHER'S MAIDEN NAME: Sarah E. Martin
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: 578-10-8782
17. INFORMANT Address: Gerald G.Keller,Franklin Manor,Churchton, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bleeding Esophageal varices — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO
(b): Cirrhosis of liver — unknown
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 17, 1961 to March 14, 1961, that I last saw the deceased alive on March 14, 1961, and that death occurred at 11:50 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Willard F. Smith M.D.
ADDRESS (Street, city or town, state): Shady Side, Maryland
DATE SIGNED: 3/15/61
PHYSICIAN'S NAME (Type): WILLARD F. SMITH, MD

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 3-17-61
22c. NAME OF CEMETERY OR CREMATORY: Hampstead Cemetery
22d. LOCATION (City, town, or county) (State): Hampstead,Md

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Wm.Cook,Inc., 1217 St.Paul Street,Zone 2
24a. REC'D BY REGISTRAR DATE: MAR 20 '61
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 11/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2644

CERTIFICATE OF DEATH

Reg. Dist. No. 62624

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Glen Burnie~~ Earleigh
c. LENGTH OF STAY IN 1b: Hts. 15 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: P.O. box 54, Pasadena P.O., Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: A. Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Glen Burnie~~ Earleigh Hghts.
d. STREET ADDRESS: same as 1-d.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Alfred — Middle nevin — Last Kelly Jr.

4. DATE OF DEATH: Month March — Day 30 — Year 19, 1

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11-2- 1925

9. AGE (In years last birthday): 35 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): foreman

10b. KIND OF BUSINESS OR INDUSTRY: construction

11. BIRTHPLACE (State or foreign country): BALT., MD.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ALFRED NEVIN SR (DEC)

14. MOTHER'S MAIDEN NAME: MRS ELIZ. BOSS (DEC)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 218-18-8471

17. INFORMANT: Wife-Elizabeth Kelly-Same address. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute myocardial infarct-posterior wall. — INTERVAL BETWEEN ONSET AND DEATH: sudden

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Previous infarct, same area. — 7wks ago.

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Previously overweight, borderline hypertension.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): No injury.

20c. TIME OF INJURY: Hour — o. m. / p. m. ----- Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): -------

20f. (City or town) (County) (State): ------

21. I certify that I attended the deceased from 9 Feb, 1961, to 30 Marck, 1961, that I last saw the deceased alive on 29 March, 1961, and that death occurred at 4:30 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: H. F. Manuzak M.D. — ADDRESS (Street, city or town, state): 425 S. Ritchie Hwy., — DATE SIGNED: 30 March 1961

PHYSICIAN'S NAME (Type): H.F. Manuzak, M.D. — Glen Burnie, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3 rd. April '61

22c. NAME OF CEMETERY OR CREMATORY: Glen Haven Cemetery

22d. LOCATION (City, town, or county) (State): Glen Burnie, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: H. F. Livingston — ADDRESS: Glen Burnie, Md.

24a. REC'D BY REGISTRAR — DATE APR 4 '61

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2645 — Reg. Dist. No. 12625

1. PLACE OF DEATH
a. COUNTY: A.A. Co — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Linthicum
c. LENGTH OF STAY IN 1b: 7yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Medova Rd & Dienning Ave

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: A.A. Co
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Linthicum X
d. STREET ADDRESS: Medova Rd & Dienning Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Emma — Middle M — Last Miller Keyser
4. DATE OF DEATH: Month March — Day 15 — Year 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 3 Jan 1894
9. AGE (In years last birthday): 67 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY: Glass Co
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Miller
14. MOTHER'S MAIDEN NAME: Julia Weidemeyer

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 219-00-6658
17. INFORMANT: Wilbur Keyser — Address: 711 Maisel St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 15/X Adenocarcinoma of Stomach — INTERVAL BETWEEN ONSET AND DEATH: 6 months
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 12/20, 1960, to 3/14, 1961, that I last saw the deceased alive on 3/14, 1961, and that death occurred at 5:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Bahram Sina, M.D. — ADDRESS (Street, city or town, state): 529 Camp Meade Rd. Linthicum, Md. — DATE SIGNED
PHYSICIAN'S NAME (Type): BAHRAM SINA

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 17 March 1961
22c. NAME OF CEMETERY OR CREMATORY: Balto National
22d. LOCATION (City, town, or county) (State): Balto Md

23. FUNERAL DIRECTOR'S SIGNATURE: Edward Clarkson — ADDRESS: 329 Wash Blvd
24a. REC'D BY REGISTRAR DATE: MAR 17 '61
24b. REGISTRAR'S SIGNATURE: Clifford S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2646 02626

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

1. **PLACE OF DEATH**
   a. COUNTY: A A
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
   c. LENGTH OF STAY IN MARYLAND: 7/3/58
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
   d. STREET ADDRESS: 1706 Linden Avenue
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Julia; Middle: ; Last: Kilson

4. **DATE OF DEATH**: Month: 3; Day: 5; Year: 1961

5. SEX: F

6. COLOR OR RACE: N

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2-16-81

9. AGE (In years last birthday): 80 yrs. IF UNDER 1 YEAR: Months: ; Days: IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): UNKNOWN

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: UNKNOWN

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): UNKNOWN

16. SOCIAL SECURITY NO: don't know

17. INFORMANT: Address: Medical Record

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute heart failure assoc. senility — INTERVAL BETWEEN ONSET AND DEATH: [illegible]

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): CBS assoc. & Arteriosclerotic CVD

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 7/3/ 19 58 to 3/5/ 19 61, that (I) (we) last saw the deceased alive on 3/5/ 19 61, and that death occured at 2:20 P.M., from the causes and on the date stated above.

22a. SIGNATURE: [signature]

22b. DATE SIGNED: 3/5/61

22c. PHYSICIAN'S NAME (Type): L. BENEDICT M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☑ STAFF PHYS. ☐ M.D.

22d. ADDRESS: CROWNSVILLE STATE HOSPITAL

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/9/61

23c. NAME OF CEMETERY OR CREMATORY: Chesterfield Cem.

23d. LOCATION (City, town or county) (State): Centreville, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Kenneth Wadey

ADDRESS: Chesterfield, Md.

25a. REC'D BY REGISTRAR DATE: MAR 8 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2647 0262

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brooklyn Park
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 131 Meadow Road

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brooklyn Park
d. STREET ADDRESS: 131 Meadow Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Fleming — Middle: K. — Last: Knowles

4. DATE OF DEATH: Month: March — Day: 17, — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 1, 1904

9. AGE (In years last birthday): 56 yrs

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Service Man

10b. KIND OF BUSINESS OR INDUSTRY: Outdoor Advertising

11. BIRTHPLACE (State or foreign country): Balto. Md.

12 CITIZEN OF WHAT COUNTRY?: U. S.

13. FATHER'S NAME: Clarence C. Knowles

14. MOTHER'S MAIDEN NAME: Pauline Keck

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO: 216-10-0476

17 INFORMANT: Mrs. Emma Knowles — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): coronary occlusion —
DUE TO
(b): hypertensive cardio vascular disease. — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

442X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Hour: — o m / p. m. — Month: — Day: — Year: 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from 10/25 1954 to 3/17 19 61, that (I) (we) last saw the deceased alive on 3/17 1961, and that death occurred at 3 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Philip W Keister, M.D. M.D. — ATTENDING PHYS ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3/17/61

22c. PHYSICIAN'S NAME (Type): Philip W. Keister

22d. ADDRESS: 302 Patapsco Ave Balto 25

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: March 20, 1961

23c NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

23d LOCATION (City, town, or county) (State): Hitchie Hwy. A. A. Co., Md.

24. FUNERAL DIRECTOR'S SIGNATURE: George J. Gence
ADDRESS: 4001 Hitchie Hwy.

25a REC'D BY REGISTRAR DATE: MAR 22 '61

25b. REGISTRAR'S SIGNATURE: Clarence E. Krause

George J. Gence

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2648

CERTIFICATE OF DEATH

02628

1 PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 119 CHARLES ST.

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MD. — b. COUNTY: A. A. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS 10
d. STREET ADDRESS: 119 CHARLES ST. 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: EDITH — Middle: CHILDS — Last: KOOLAGE
4. DATE OF DEATH: Month: 3 — Day: 20 — Year: 1961
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 9-3-1889
9. AGE (In years last birthday): 71 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PUBLIC SCHOOL
10b. KIND OF BUSINESS OR INDUSTRY: TEACHER
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: WILLIAM F. CHILDS SR.
14. MOTHER'S MAIDEN NAME: MARY BOSWELL
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: MRS. FRANK M. CORNER — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): cerebral metastasis of carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 4-5 mos.

DUE TO (b): epidermoid carcinoma of nose — 3½ yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): X-ray therapy to face for acne — 50 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11-30 1960 to 3-20 1961, that (I) (we) last saw the deceased alive on 3-19 1961, and that death occurred at 6:00 A.M. from the causes and on the date stated above

22a. SIGNATURE: Barber C. Palmer Jr. M.D.
ATTENDING PHYS ☑ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 3-21-61
22c. PHYSICIAN'S NAME (Type): BARBER C. PALMER JR.
22d. ADDRESS: 77 FRANKLIN ST, ANNAPOLIS, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 3-22-61
23c. NAME OF CEMETERY OR CREMATORY: CEDAR BLUFF
23d. LOCATION (City, town, or county) (State): ANNAPOLIS MD.

24. FUNERAL DIRECTOR'S SIGNATURE: John M. Poyton + Sons — ADDRESS: Annapolis, Md.
25a. REC'D BY REGISTRAR DATE: MAR 22 '61
25b. REGISTRAR'S SIGNATURE: Clinton L. Francis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2649 — 02629

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 31 A Murray Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edward — Middle: F. — Last: LEONARD

4. DATE OF DEATH: Month: March — Day: 27 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: September 22, 1907

9. AGE (In years last birthday): 53 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pres. Leonard Iron Fitting Goods Co. Annapolis

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Charles Leonard

14. MOTHER'S MAIDEN NAME: Louise Bondoy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wear or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Laurd D. Leonard (2) — Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO (b): Cerebral Arteriosclerosis — 1 yr.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Arteriosclerosis Generalized — 1 yr.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~the hospital~~) attended the deceased from DEc. 1, 19 59 to MAr. 27, 19 61, that (I) (~~he~~) last saw the deceased alive on Mar. 27, 1961, and that death occured at 6:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: James R. Martin M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3-29-61

22c. PHYSICIAN'S NAME (Type): James R. Martin

22d. ADDRESS: 6 Shaw St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3-30-1961

23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Memorial

23d. LOCATION (City, town or county): Annapolis (State): Md.

24. FUNERAL DIRECTOR'S SIGNATURE: John M. Sayler Sons — ADDRESS: Annapolis Md

25a. REC'D BY REGISTRAR DATE: MAR 30 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Krause

1

FOR STATE HEALTH DEPT.

M

TO DUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please explain. Sign the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME 5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2650 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02630

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Dorsey
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Baltimore-Washington Expressway

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Harwood Park
d. STREET ADDRESS: 7119 Athol Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HENRY Middle JOHN Last LEWIS

4. DATE OF DEATH: Month March Day 5, Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3/23/97

9. AGE (In years last birthday): 63 yrs. IF UNDER 1 YEAR: Months, Days. IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Disabled Veteran for 27 years

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Huntington, N. Y.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry J. Lewis

14. MOTHER'S MAIDEN NAME: Elizabeth ~~Greeley~~ Greeley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): First World War

16. SOCIAL SECURITY NO.: ?

17. INFORMANT: Mrs. Helen Lewis (wife) Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH

4 2 2 . 1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from. Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

SIGNATURE: R S Fisher M.D.

EXAMINER'S NAME (Type): Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

Address (Street, city, town, or county)

DATE SIGNED: 3/6/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/9/1961

22c. NAME OF CEMETERY OR CREMATORY: Baltimore National Cem.

22d. LOCATION (City, town, or country) (State): Baltimore Maryland

23. FUNERAL DIRECTOR ADDRESS: Howard H. Hubbard 4107 Wilkens Ave.

24a. REC'D BY REGISTRAR DATE: MAR 8 '61

24b. REGISTRAR'S SIGNATURE: Clifton L. Ho...

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2651

CERTIFICATE OF DEATH

02C31

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN (b): 13 YRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): USNH ANNAPOLIS, MD.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 ANNAPOLIS
d. STREET ADDRESS: 118 N. GLEN AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: EDITH — Middle: HILL — Last: MATTIE

4. DATE OF DEATH: Month: MARCH — Day: 11 — Year: 19 61

5. SEX: FEMALE

6. COLOR OR RACE: CAU

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8-15-05

9. AGE (In years last birthday): 55 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOMEMAKER

10b. KIND OF BUSINESS OR INDUSTRY: - - -

11. BIRTHPLACE (County & State, or foreign country): MASS.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: JAMES DICKEY HILL

14. MOTHER'S MAIDEN NAME: ELIZABETH BURROWS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): - - -

16. SOCIAL SECURITY NO.:

17. INFORMANT: USN4 ANNAPOLIS, MARYLAND
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): MULTIPLE ABDOMINAL ABSCESSES — INTERVAL BETWEEN ONSET AND DEATH: 10 DAYS
DUE TO (b): METASTATIC CARCINOMA OF COLON — 1½ YRS
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour e.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 3-11 19 61 to 3-11 19 61, that (I) (~~XX~~) last saw the deceased alive on 3-10 19 61, and that death occured at 1230PM from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 3-11-61

22c. PHYSICIAN'S NAME (Type): S. (N) BUSCH LT MC USNR

22d. ADDRESS: USNH ANNAPOLIS, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Mar. 14-1961
23c. NAME OF CEMETERY OR CREMATORY: Naval Academy Cem
23d. LOCATION (City, town or county): Annapolis (State): Md.

24 FUNERAL DIRECTOR'S SIGNATURE: John M. Fleyla Sons
ADDRESS: Annapolis Md.

25a. REC'D BY REGISTRAR DATE: MAR 14 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2652 — 02652

1. PLACE OF DEATH
a. COUNTY: A. A. Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 127 Club Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: A.A. Co,
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Pasadena
d. STREET ADDRESS: 127 Club Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: W. — Middle: Harold — Last: Miles

4. DATE OF DEATH: Month: March — Day: 7, — Year: 1961

5 SEX	6. COLOR OR RACE	7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min.
Male	White		Oct. 30, 1887	73 yrs.		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Ret. Clerk-Supreme Court	State of Md.	Baltimore, Maryland	U.S.A.

13. FATHER'S NAME: S. Milton Miles

14. MOTHER'S MAIDEN NAME: Clara Bodensick

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO:

17. INFORMANT Address: Mrs. Miriam Eslinger-1649 Waverly Way

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cerebral hemorrhage	30 mins.
DUE TO (b)	Hypertension	5 years
DUE TO (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Hour / Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
o. m. p. m. 19					

21 **I certify** that (I) ~~(this hospital)~~ attended the deceased from July 15 19 60 to Mar. 7 1961, that (I) ~~(we)~~ last saw the deceased alive on Mar. 5 19 61 and that death occurred at 7 P.M. from the causes and on the date stated above

22a SIGNATURE	ATTENDING PHYS. X / MED DIRECTOR ☐ / STAFF PHYS. ☐	22b DATE SIGNED
R. M. McLaughlin M D		Mar. 7. 1961

22c PHYSICIAN'S NAME (Type)	22d ADDRESS
R. M. McLaughlin	3108 Mountain Rd. Pasadena, Md.

23a BURIAL, CREMATION REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	3-11-61	Loudon Park	Baltimore, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
[redacted] & Sons	North Fenwick Ave Baltimore 17, Md	MAR 9 '61	William S. Riana

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2653 02033

1. PLACE OF DEATH a. COUNTY: A A. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 12 Church Circle

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Md. b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 1317 N. Glen Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Morris Middle: Milton Last: Moesch
4. DATE OF DEATH: Month: 3 Day: 23 Year: 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Apr. 29th 1888
9. AGE (In years last birthday): 72 yrs
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret Ordnance + Armory
10b. KIND OF BUSINESS OR INDUSTRY: U.S Naval Academy
11. BIRTHPLACE (State or foreign country): Ill.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Charles Moesch
14. MOTHER'S MAIDEN NAME: Ella Amelia Sigfried

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Priscilla Cecelia Moesch (2) Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO (b): Arteriosclerotic Heart Disease — ?

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Asthma, Bronchitis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3-23-1961, to 3-23-1961, that (I) (we) last saw the deceased alive on 3-23-1961, and that death occurred at ____ M, from the causes and on the date stated above.

22a. SIGNATURE: John R. Martin M.D.
ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 3-24-61
22c. PHYSICIAN'S NAME (Type): JAMES R. MARTIN
22d. ADDRESS: 6 SHAW ST. ANNAPOLIS, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-26-1961
23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Memorial
23d. LOCATION (City, town, or county): Annapolis (State): Md

24. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Cons
ADDRESS: Annapolis Md
25a. RECD BY REGISTRAR DATE: MAR 27 '61
25b. REGISTRAR'S SIGNATURE: Clifton S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) ISM 9/59

1

FOR STATE HEALTH DEPT.

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2654 02634

1. PLACE OF DEATH
a. COUNTY: A.A. Co
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A. Anne Arundel - General.

2. USUAL RESIDENCE (Where deceased lived, If inst tut on: Residence Before admission)
a. STATE: MD
b. COUNTY: AA Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Dividing Creek Rd.
d. STREET ADDRESS: Arnold - MD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William; Middle: ; Last: Moog

4. DATE OF DEATH: Month: 3; Day: 20; Year: 1961

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-11 Feb. 1900

9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months: ; Days:
IF UNDER 24 HRS: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ch. War Off. (U.S.C.G.) Ret.

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Balto, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William H. Moog

14. MOTHER'S MAIDEN NAME: Lottie Stoker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give war or dates of service): Ret. 1 Feb. '47

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Margaret A. Moog
Address: Same As #2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Artery Disease
DUE TO (b): Hypertension
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL EXAMINER'S NAME (Type): E. Lowndes M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

DATE SIGNED: 3/20/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 24th March '61

22c. NAME OF CEMETERY OR CREMATORY: Balto. Nat'l. Cem.

22d. LOCATION (City, town, or country) (State): Balto., Md.

23. FUNERAL DIRECTOR: R. V. Leighton
ADDRESS: Glen Burnie Md.

24a. REC'D BY REGISTRAR DATE: MAR 23 '61

24b. REGISTRAR'S SIGNATURE: William S. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please secure the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2655

CERTIFICATE OF DEATH

02635

1. PLACE OF DEATH
a. COUNTY: A A — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town): Iglehart
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Route 178

2. USUAL RESIDENCE (Where deceased lived. If institution - Residence before admission)
a. STATE: Md. — b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Iglehart
d. STREET ADDRESS: Route 178
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Nora — Middle: — Last: Moran

4. DATE OF DEATH: Month: 3 — Day: 18 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov 22d 1884

9. AGE (In years last birthday): 76 yrs.

IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months / Days / Hours / Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Cambridge Md

12 CITIZEN OF WHAT COUNTRY? U. S. A

13 FATHER'S NAME: James Calloway

14 MOTHER'S MAIDEN NAME: Sarah Whaley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO: —

17. INFORMANT: Mr. John Moran — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Unknown
DUE TO (b): Rheumatic Heart Disease — Probably a predisposing
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 416X

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 1960 to March 18 1961, that (I) (~~me~~) last saw the deceased alive on Jan 1961, and that death occurred at 12:34 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Thos. L. Stephens M.D

ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b DATE SIGNED

22c PHYSICIAN'S NAME (Type)

22d ADDRESS: 38 Carvill Cambridge Md

23a. BURIAL, ~~CREMATION~~, REMOVAL (Specify): MAR 22-61

23b DATE THEREOF

23c NAME OF CEMETERY OR CREMATORY: CEDAR HILL CEM.

23d LOCATION (City, town, or county): A. A. Co. (State): MD.

24. FUNERAL DIRECTOR'S SIGNATURE: JOHN M. TAYLOR SON

ADDRESS: ANNAPOLIS MD

25a REC'D BY REGISTRAR DATE: MAR 22 '61

25b. REGISTRAR'S SIGNATURE: Curtis S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A1S (4)
1SM 9/59

1

FOR STATE HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2656 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02636

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Baltimore 25
c. LENGTH OF STAY IN 1b: MARYLAND — Few minutes
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 229 Berlin Ave. Potapsco Park

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Same
b. COUNTY: Same
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Same
d. STREET ADDRESS: Same
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Norman Middle Muldrow Last

4. DATE OF DEATH: Month March Day 29th. Year 19 61

5. SEX: M

6. COLOR OR RACE: C

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9/10/96

9. AGE (In years last birthday): 64 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Self employed, No work for 3 years.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Darlington.S.C.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Irvin Muldrow

14. MOTHER'S MAIDEN NAME: Emma Lunn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): Yes. World War No 1

16. SOCIAL SECURITY NO.: 218-10-3013

17. INFORMANT: Mrs.Philip Marner (Oldest daughter) Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Self strangulation with a clothes line. — INTERVAL BETWEEN ONSET AND DEATH: Few minutes
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Placed a clothes line around his neck that he fastened to a rafter

20c. TIME OF INJURY Hour 4 a.m. p.m. Month, Day, Year 3/29/61 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) Baltimore 25, (County) A.A. (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gustave H Faubert M.D

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 3/29/61

EXAMINER'S NAME (Type): Gustave H. Faubert, M.D.

Address (Street, city, town, or county): Glen Burnie, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4/3/1961

22c. NAME OF CEMETERY OR CREMATORY: W.H. Carlson Cem.

22d. LOCATION (City, town, or county) (State): Balto Md.

23. FUNERAL DIRECTOR: Mrs Katie R. Williams

ADDRESS: 322 N Schroeder St.

24a. REC'D BY REGISTRAR DATE APR 4 '61

24b. REGISTRAR'S SIGNATURE: Adrian L. Kinna

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2657

CERTIFICATE OF DEATH

Reg. Dist. No. 02637

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. NAVAL HOSPITAL, ANNAPOLIS, MD.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ANNA ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SEVERNA PARK
d. STREET ADDRESS: MANHATTEN MANOR
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First PAUL — Middle NORMAN — Last MYATT

4. DATE OF DEATH: Month MARCH — Day 10 — Year 19 61

5. SEX: MALE

6. COLOR OR RACE: CAUC.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 18 MAY 1912

9. AGE (In years last birthday): 48 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ENLISTED USN

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MASSACHUSETTS

12. CITIZEN OF WHAT COUNTRY? UNITED STATES

13. FATHER'S NAME: Joseph MYATT

14. MOTHER'S MAIDEN NAME: Annie BEACON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WW II

16. SOCIAL SECURITY NO:

17. INFORMANT — Address: (Wife) Frances MYATT, SEVERNA PARK, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 1 HOUR
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Chemical tracheobronchitis
DUE TO
(c): Aspiration

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): INTESTINAL OBSTRUCTION — CA STOMACH

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8 February, 1961, to 10 March, 1961, that I last saw the deceased alive on 10 March, 19 61, and that death occurred at 3:04P M, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) — DATE SIGNED

ACTUAL SIGNATURE: Stephen B. Hiltabidle, M.D. — 10 March 1961

PHYSICIAN'S NAME (Type): Stephen B. HILTABIDLE, LT MC USNR U. S. NAVAL HOSPITAL, ANNAPOLIS, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 3/14/61
22c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NATIONAL
22d. LOCATION (City, town, or county) (State): ARLINGTON VA

23. FUNERAL DIRECTOR'S SIGNATURE: JOHN M. TAYLOR, Son — ADDRESS: ANNAPOLIS MD.

24a. REC'D BY REGISTRAR DATE: MAR 14 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be [illegible] by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2658 **CERTIFICATE OF DEATH** 02638

1 PLACE OF DEATH

1. NAME OF DECEASED (Type or Print): ELNORA PARKER
2. DATE OF DEATH: March 26, 1961

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION: Anne Arundel County
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 4109 Bellgrore Rd Baltimore 25, Md.

4. USUAL RESIDENCE (Where deceased lived If institution residence before admission)
A. STATE: MARYLAND B. COUNTY: QUEEN ANNE
C. CITY OR TOWN (If outside city limits, write RURAL and give township): WYE MILLS RURAL
D. STREET ADDRESS (If rural, give location): RT. 50 -

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	W	MARRIED	3/9/1901	60		

10.A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	NORTH CAROLINA	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
JOHN G BEASLEY	YOUNG OR HAWKIN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
—	—	MR. PARKER - WYE MILLS. MD.

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

		INTERVAL BETWEEN ONSET AND DEATH
I (A)	Adenocarcinoma of G. I. tract	6 months
DUE TO (B)	Generalized metastases	
DUE TO (C)	Diabetes mellitus	

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	19A. DATE OF OPERATION	19B CONDITION FOR WHICH OPERATION WAS PERFORMED	20. AUTOPSY?
			YES ☐ NO ☒

22. I certify that (I) (this hospital) attended the deceased from February 10 19 61 to March 26 19 61, that (I) (we) last saw the deceased alive on March 26 1961, and that in (my) (our) opinion death occurred at 3:45 p.m., from the causes and on the date stated above.

23A. SIGNATURE	23B ADDRESS	23C. DATE SIGNED
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS ☐ Robert Dabolny M D	642 Washington Blvd. #30, Balto.	March 26, 1961

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D LOCATION (City, town, or county) (State)
BURIAL	3/29/61	YOUNG CEMETERY	BENSON - NORTH CAROLINA

25A. DATE REC'D BY HEALTH DEPT.	25B NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAR 27 '61	Clinton L. Kraus	JAMES G. JAFFE & JR - WESTMINSTER MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2659

CERTIFICATE OF DEATH

02639

Item 2 Film G283 3/20/61 iwk

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 58 Washington Street, Annapolis
d. STREET ADDRESS: 58 Washington St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Samuel; Middle: ; Last: PERRITT

4. DATE OF DEATH: Month: March; Day: 13; Year: 1961

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1-31-1906

9. AGE (In years last birthday): 55 yrs. IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; M'n.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor

10b. KIND OF BUSINESS OR INDUSTRY: Natl. Guard armory

11. BIRTHPLACE (County & State, or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George D. Perritt

14. MOTHER'S MAIDEN NAME: Lottie Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Bernice Perritt - Annapolis, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 4 wks.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m.; Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from March 13, 1961 to March 13, 1961, that (I) (xxx) last saw the deceased alive on March 13, 1961, and that death occured at 4 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Edwin Hedeman M.D.

22c. PHYSICIAN'S NAME (Type): John L. Hedeman

ATTENDING PHYS. XX MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3/13/61

22d. ADDRESS: 121 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3-18-61

23c. NAME OF CEMETERY OR CREMATORY: Brewer Hill

23d. LOCATION (City, town or county) (State): Annapolis, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: William Reese

ADDRESS: 12 Annap Md.

25a. REC'D BY REGISTRAR DATE: MAR 15 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. See page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2660 Reg. Dist. No. 02640

1. PLACE OF DEATH
a. COUNTY: Lothian MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lothian
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: McKendree Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: ~~Lothian~~ Maryland b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural
d. STREET ADDRESS: McKendree Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒X

3. NAME OF DECEASED (Type or print): First: Alexander Middle: Last: Powell
4. DATE OF DEATH: Month: March Day: 19 Year: 1961
5. SEX: Male
6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒X DIVORCED ☐
8. DATE OF BIRTH: 1-20-1896
9. AGE (In years last birthday): 65 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): General Laborer
10b. KIND OF BUSINESS OR INDUSTRY: ~~xxxxxxxxxxx~~
11. BIRTHPLACE (State or foreign country): Anne Arundel Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Gladys Stergiou- Address: 27 Larkins St. Anna. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Shot gun wound right side of neck (suicide) — INTERVAL BETWEEN ONSET AND DEATH:
976X
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year: Hour a. m. 9:40 p. m. 3/19 1961
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Lothian (County) A A (State) Md

21. I certify that I attended the deceased from not at all, 19____, to_____, 19____, that I last saw the deceased alive on_____, 19____, and that death occurred at_____M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Emily H. Wilson M.D. ADDRESS (Street, city or town, state): Lothian Maryland DATE SIGNED:

PHYSICIAN'S NAME (Type): Emily H. Wilson M.D. Deputy Coroner

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-23-61
22c. NAME OF CEMETERY OR CREMATORY: Moses
22d. LOCATION (City, town, or county) (State): Drury - Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: C.E.HICKS III ADDRESS: Annapolis, Maryland
24a. REC'D BY REGISTRAR DATE: MAR 23 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

Items 18-21 Film 285 4 [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2661 02641

FOR STATE HEALTH DEPT. USE

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): A. A. General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Shadyside
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Maurice — Middle: B. — Last: POWELL, JR.

4. DATE OF DEATH: Month: March — Day: 22, — Year: 1961

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-19-1957

9. AGE (In years last birthday): 3 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Maurice B. Powell

14. MOTHER'S MAIDEN NAME: Fannie White

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Maurice B. Powell — Address: Shadyside

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 74 X — Severe brain swelling following cardiac arrest during circumcision.
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.): Severe brain swelling following cardiac arrest during circumcision

20c. TIME OF INJURY: Hour 10:30 a.m. p.m. — Month, Day, Year: 3/20/61 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Hospital

20f. (City or town) (County) (State): Anne Arundel Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: William V. Lovitt, Jr. M D.

PRINTED NAME (Type): William V. Lovitt, Jr., M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

Address (Street, city, town, or county):

DATE SIGNED: March 23, 1961

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-25-1961

22c. NAME OF CEMETERY OR CREMATORY: St. Mathew's

22d. LOCATION (City, town, or country) (State): Shadyside Md.

23. FUNERAL DIRECTOR: William Rose II — ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: MAR 24 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2662 02642

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
c. LENGTH OF STAY IN this place: 14 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): District Training School, Children's Center

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C.
d. STREET ADDRESS: 426 - 6th St. N.E., Apt. 104
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: David; Middle: Roesha; Last: Pugh

4. DATE OF DEATH: Month: March; Day: 7; Year: 1961

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: March 6, 1959

9. AGE (In years last birthday): 2 yrs. IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Institutionalized

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (County & State, or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Wesley Pugh

14. MOTHER'S MAIDEN NAME: Arlene Beachem

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): --
(If yes give war or dates of service): --

16. SOCIAL SECURITY NO.: --

17. INFORMANT Address: SOCIAL SERVICE, CHILDREN'S CENTER, LAUREL, MD.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Aspiration — INTERVAL BETWEEN ONSET AND DEATH: Immediate

753.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hypoplasia of the brain with hydrocephalus
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): -----

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): ---

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 12/1/60, 19, a.m. to 3/7/61, 19, that (I) (we) last saw the deceased alive on 3/7/61, 19, and that death occured at 8.25, from the causes and on the date stated above.

22a. SIGNATURE: James E Boyland M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: March 8, 1961

22c. PHYSICIAN'S NAME (Type): James E. Boyland, M.D.

22d. ADDRESS: Children's Center, Laurel, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Mar 9, 1961

23c. NAME OF CEMETERY OR CREMATORY: District Training School

23d. LOCATION (City, town or county) (State): Laurel, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: John Dwiletz ADDRESS: Asst Supt DTS

25a. REC'D BY REGISTRAR DATE: MAR 13 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2663 — 02643

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 73 West St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bonnie — Middle: Gay — Last: RAGLE

4. DATE OF DEATH: Month: March — Day: 24 — Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 13, 1961
9. AGE (In years last birthday): yrs. 10 — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours 5 — Min. 55
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.
13. FATHER'S NAME: Charles Samuel RAGLE
14. MOTHER'S MAIDEN NAME: Marylin Joann SWIGERT
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give wer or dates of service): —
16. SOCIAL SECURITY NO:
17. INFORMANT: Hospital records — Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): —
DUE TO (b): —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Prematurity

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (~~He~~) attended the deceased from Mar. 13, 1961, to Mar. 23, 1961, that (I) (~~He~~) last saw the deceased alive on Mar. 23, 1961, and that death occured at 2:00 A.M., from the causes and on the date stated above.

22a. SIGNATURE: James W Hayes M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type): James W. Hayes
22d. ADDRESS: Medical Arts Bldg., Severna Park, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-26-1961
23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Memorial
23d. LOCATION (City, town or county): Annapolis (State): Md

24. FUNERAL DIRECTOR'S SIGNATURE: John M. Hayes Sons — ADDRESS: Annapolis Md.
25a. RECD BY REGISTRAR: MAR 27 '61 — DATE
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2664 02644

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ft Geo G. Meade
c. LENGTH OF STAY IN 1b: 1 hr 7 Min
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Army Hospital, Ft Geo G. Meade, Md

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: -
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 21201-4
d. STREET ADDRESS: 2000 Mount Royal Terrace
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First — Middle — Last: ROSS

4. DATE OF DEATH: Month: March; Day: 20; Year: 1961

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 20, 1961

9. AGE (In years last birthday): yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours: 1; Min.: 7

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): N/A

10b. KIND OF BUSINESS OR INDUSTRY: N/A

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Ross

14. MOTHER'S MAIDEN NAME: Delores Elizabeth Harvey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): N/A
(If yes, give war or dates of service): N/A

16. SOCIAL SECURITY NO: N/A

17. INFORMANT Address: James Ross, 2000 Mount Royal Terrace, Balto, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Hemoperitoneum; subcapsular hemotomas of liver — INTERVAL BETWEEN ONSET AND DEATH: Unknown

57 6X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): petechial pleural surfaces of lungs and pericardium

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour, a. m., p. m., Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Mar. 20, 1961, to Mar. 20, 1961, that (I) (we) last saw the deceased alive on Mar. 20, 1961, and that death occurred at ___ M. from the causes and on the date stated above.

22a. SIGNATURE: John Z. Fichtner M.D

ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: March 20, 1961

22c. PHYSICIAN'S NAME (Type): JOHN Z. FICHTNER, CAPT, MC

22d. ADDRESS: U.S. ARMY HOSPITAL, FT GEO G MEADE, MD

23a. ~~BURIAL~~ CREMATION REMOVAL (Specify)

23b. DATE THEREOF: 22 Mar 61

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county) (State)

24. FUNERAL DIRECTOR'S SIGNATURE: William J. Steeger Mgr.

ADDRESS: Ft Geo G. Meade Maryland

25a. REC'D BY REGISTRAR DATE: MAR 27 '61

25b. REGISTRAR'S SIGNATURE: Clifton L. Finnis

5141XV3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2665

CERTIFICATE OF DEATH

Reg. Dist. No. 03870

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel, Md.
c. LENGTH OF STAY IN 1b: 12 months
d. NAME OF HOSPITAL OR INSTITUTION: District Training School Children's Center, Laurel, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C.
d. STREET ADDRESS: 3412 - 23rd St. S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Rodney — Middle: Tyrone (Jenkins) — Last: Scott

4. DATE OF DEATH: Month: March — Day: 31 — Year: 19 61

5. SEX: male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 24, 1958

9. AGE (In years last birthday): 3 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): --

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (State or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Calvin William Jenkins (putative)

14. MOTHER'S MAIDEN NAME: Wanda Marie Scott

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

INFORMANT: Address: Children's Center, Laurel, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Aspiration Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: Several days
DUE TO
(b): Hydrocephalus
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Mental Retardation

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour, o m. p. m., Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/5/ 19 60, to 3/31/61 19 ___, that I last saw the deceased alive on 3/31/61 19 ___, and that death occurred at 11 p. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: George T Economos M.D.
ADDRESS (Street, city or town, state): Children's Center, Laurel, Md.
DATE SIGNED: 3/31/61

PHYSICIAN'S NAME (Type): George T. Economos, M.D.

22a. BURIAL, CREMATION, REMOVAL: XXXXX

22b. DATE THEREOF: 4/5/61

22c. NAME OF CEMETERY OR CREMATORY: Lincoln Memorial

22d. LOCATION (City, town, or county) (State): Washington, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: ADDRESS: Morris A. Carter - 305 H St. NW Washington, D.C.

24a. REC'D BY REGISTRAR DATE: APR 25 '61

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2666

02645

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 4 mos.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 518 Morningside Drive

2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission)
a. STATE: Md.
b. COUNTY: AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Glen Burnie
d. STREET ADDRESS: 518 Morningside Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Emma; Middle; Last Sickenberger

4. DATE OF DEATH: Month March; Day 20; Year 19 61

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Jan. 18, 1869

9. AGE (In years last birthday): 92 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Johan Conrad Roth

14. MOTHER'S MAIDEN NAME: Dorothea Grebe Klein

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO:

17. INFORMANT: Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage
DUE TO (b): Hypertensive Cardio-Vascular Disease
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 4 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2-20 19 61, to 3-20 19 61, that (I) (we) last saw the deceased alive on 3-15-61 19 ___, and that death occurred at 6A M, from the causes and on the date stated above.

22a. SIGNATURE: C R MacDonald MD M.D.
ATTENDING PHYS X MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 3-20-61

22c. PHYSICIAN'S NAME (Type): C. R. MacDonald, M.D.

22d. ADDRESS: 204 Crain Hghy, SW, Glen Burnie

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/22/61
23c. NAME OF CEMETERY OR CREMATORY: Hillside Cemetery
23d. LOCATION (City, town, or county) (State): Rutherford, N. J.

24. FUNERAL DIRECTOR'S SIGNATURE: Hopping and Kirkley
ADDRESS: Glen Burnie, Md.

25a. REC'D BY REGISTRAR DATE: MAR 21 '61

25b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2667 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 02646

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Queen Anne
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Rural

2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE: Maryland — b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bristol
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Everest — Middle: McArthur — Last: Simms

4. DATE OF DEATH: Month: 3 — Day: 29 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: Col.

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-21-1942

9. AGE (In years last birthday): 18 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lumberman

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Dunkirk, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Walter Simms

14. MOTHER'S MAIDEN NAME: Elsie Parker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: Elsie Simms — Address: Bristol, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Crushing Injury to Chest — INTERVAL BETWEEN ONSET AND DEATH: Instant
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Tree fell on Subject

20c. TIME OF INJURY: Hour: o m. — Month, Day, Year: 3/29 1961

20d. INJURY OCCURRED: While at work ☒ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Farm

20f. (City or town): A.A.Co. — (County): MD — (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. Linhardt M.D.
EXAMINER'S NAME (Type): E. Linhardt
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 3-29-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4-1-61
22c. NAME OF CEMETERY OR CREMATORY: Hooes
22d. LOCATION (City, town, or county): Bowery Md. (State)

23. FUNERAL DIRECTOR'S SIGNATURE: William Reese, II
ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: APR 3 '61
24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give [illegible] 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the [illegible] Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS ATSME 5M 2. 57

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2668

CERTIFICATE OF DEATH

02647

1 PLACE OF DEATH
a. COUNTY: A.A. Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SEVERNA PARK
c. LENGTH OF STAY IN 1b: 25 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 110 MAPLE Ave

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: A.A. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SEVERNA PARK
d. STREET ADDRESS: 110 MAPLE AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First ELIZABETH — Middle — Last SLAVIN

4. DATE OF DEATH: Month MARCH — Day 31 — Year 1961

5 SEX: FEMALE — 6 COLOR OR RACE: WHITE — 7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8 DATE OF BIRTH: 1-23-1884 — 9. AGE (In years last birthday): 77 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: FRANCIS X. LIVINGSTON
14. MOTHER'S MAIDEN NAME: MARY M. MINNICK

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17 INFORMANT: Address: MR. FRANK SLAVIN - 108 MAPLE AV.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Heart failure — INTERVAL BETWEEN ONSET AND DEATH: 3 days.

DUE TO (b): Degenerative cardiovascular disease — 10 yrs.

DUE TO (c): —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 27 Mar 1961, to 31 Mar 1961, that (I) (we) last saw the deceased alive on 31 Mar 1961, and that death occurred at 5:15 P M, from the causes and on the date stated above.

22a SIGNATURE: Gene D. Trettin M D
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b DATE SIGNED: 1 April 1961
22c PHYSICIAN'S NAME (Type): GENE D. TRETTIN
22d. ADDRESS: 715 Cotter Rd. Glen Burnie Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b DATE THEREOF: 4-4-61
23c. NAME OF CEMETERY OR CREMATORY: GLEN HAVEN CEM.
23d LOCATION (City, town, or county) (State): GLEN BURNIE, MD.

24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Barranco
ADDRESS: Severna Pk. Md.
25a. REC'D BY REGISTRAR: DATE APR 4 '61
25b REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2669 Items 1c & 2d, film Gc84 4/12/61 iwk 02648

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: A.A.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN MARYLAND: 21 years 8 Mon. 27 dys
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hosp.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MD
b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Glen Burnie
d. STREET ADDRESS: Solley P.O.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Ronald; Middle: ; Last: Smith

4. DATE OF DEATH: Month: 3; Day: 25; Year: 1961

5. SEX: M

6. COLOR OR RACE: Negro

7. MARRIED ☐ **NEVER MARRIED** ☑ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 9-25-34

9. AGE (In years last birthday): 26 yrs. IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): A.A. Co. Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Charles Smith

14. MOTHER'S MAIDEN NAME: Mary Bowyer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mary Smith Address: 2829 Woodmoor Ave

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): UR Infection
DUE TO (b): Mongolian idiocy
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 9 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 3/26/61 to 3/25/61, 1961, that (I) (we) last saw the deceased alive on 3/25/61, 1961, and that death occured at 5:30 A.M., from the causes and on the date stated above.

22a. SIGNATURE: G.B. Wilkins, M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3/25/61

22c. PHYSICIAN'S NAME (Type): G.B.Wilkins

22d. ADDRESS: Crownsville Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/28/61

23c. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem

23d. LOCATION (City, town or county) (State): Baltimore Md.

24 FUNERAL DIRECTOR'S SIGNATURE: [illegible]

ADDRESS: 322 [illegible]

25a. REC'D BY REGISTRAR DATE: MAR 29 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2670 — Reg. Dist. No. 02649

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: life resident
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: USNH, Annapolis, Maryland

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Mayo
d. STREET ADDRESS: 305 Cadel Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Maggie — Middle Estelle — Last STALLINGS

4. DATE OF DEATH: Month March — Day 26 — Year 1961

5. SEX: Female

6. COLOR OR RACE: Cauc

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Mar 25 1890

9. AGE (In years last birthday): 71 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Joseph Tucker (N)

14. MOTHER'S MAIDEN NAME: Emily Owen Howes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT: Mrs Homer Dawson — Address: Mayo Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchpneumonia, Bilateral — INTERVAL BETWEEN ONSET AND DEATH: 12 Hrs
526X
DUE TO (b): Bronchiectasis, Emphysema — 10 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Chronic Bronchitis — 20 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic Heart Disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11 July, 19 60, to 26 March, 19 61, that I last saw the deceased alive on 26 Mardh, 19 61, and that death occurred at 0520A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: E C Keene — M.D. — ADDRESS (Street, city or town, state): — DATE SIGNED: 26 March 1961

PHYSICIAN'S NAME (Type): E.C.KEENE LT MC USNR — USNH, Annapolis, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 3-29-61 — 22c. NAME OF CEMETERY OR CREMATORY: Mayo Memorial — 22d. LOCATION (City, town, or county): Mayo (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE: Owen M. Taylor Sons — ADDRESS: Annapolis Md

24a. REC'D BY REGISTRAR DATE: MAR 28 '61 — 24b. REGISTRAR'S SIGNATURE: Clifton L. Knell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director. Page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2671

CERTIFICATE OF DEATH

02650

1 Y

M

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 31 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - Annapolis
d. STREET ADDRESS: 35 Bay Drive - Bay Ridge
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF (Type or print): First: Richard — Middle: FREDERICK — Last: STONE

4. DATE OF DEATH: Month: March — Day: 13 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: December 21, 1909

9. AGE (In years last birthday): 50 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Navy

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: FRED STONE

14. MOTHER'S MAIDEN NAME: CECELIA BRAUN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: MARY K. STEELE STONE

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of the pancreas — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

15 Y X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~the physician~~) attended the deceased from Feb. 10, 1961 to Mar. 13, 1961, that (I) (~~he~~) last saw the deceased alive on Mar. 13, 1961, and that death occured at 10:00 A.M., from the causes and on the date stated above.

22a. SIGNATURE: John L. Hedeman, M.D. — M.D

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3/13/61

22c. PHYSICIAN'S NAME (Type): John L. Hedeman

22d. ADDRESS: 121 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Mar 16-1961

23c. NAME OF CEMETERY OR CREMATORY: Cedar Bluff Cemt

23d. LOCATION (City, town or county): Annapolis (State): Md

24. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons — ADDRESS: Annapolis Md

25a. REC'D BY REGISTRAR DATE: MAR 15 '61

25b. REGISTRAR'S SIGNATURE: Clifton L. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2672 — Reg. Dist. No. 02651

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: St. Mary's Rectory

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: St. Mary's Rectory Gloucester Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN Middle F. Last TAUS
4. DATE OF DEATH: Month MARCH Day 28, Year 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 21, 1909
9. AGE (In years last birthday): 51 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clergyman
10b. KIND OF BUSINESS OR INDUSTRY: Church
11. BIRTHPLACE (State or foreign country): New York, N.Y.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John J. Taus
14. MOTHER'S MAIDEN NAME: Anna M. Kohout

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW II
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Rev. John Brennan, Rector, St. Mary's Church — Address: Annapolis, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: Hours
434.4
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 19 60, to March 28 19 61, that I last saw the deceased alive on March 28, 19 61, and that death occurred at P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Elmer J. Linhardt M.D. ADDRESS (Street, city or town, state): Annapolis Md DATE SIGNED: 3/28/61

PHYSICIAN'S NAME (Type): Elmer J. Linhardt MD — Annapolis, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: March 30, 61
22c. NAME OF CEMETERY OR CREMATORY: St. Mary's
22d. LOCATION (City, town, or county) (State): Annapolis, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: [signature] ADDRESS: Hopping Funeral Home Annapolis, Md.
24a. REC'D BY REGISTRAR DATE: APR 3 '61
24b. REGISTRAR'S SIGNATURE: Clifton L. Krouse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2673

02652

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 55 Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 29 Franklin St.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 29 Franklin St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Virginia; Middle: M.; Last: Tull

4. DATE OF DEATH: Month: March; Day: 1; Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: February 2, 1870

9. AGE (In years last birthday): 91 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James M. Milbourne

14. MOTHER'S MAIDEN NAME: Harriet Dashiell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Milton L. Tull — Address: # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 Days
DUE TO
(b): Arteriosclerotic-Cardio-Vascular Disease — 4 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fracture of the right Hip — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Fall down Steps, 1959 - Oct. 1.

20c. TIME OF INJURY: Hour: 8 a. m. p. m.; Month, Day, Year: 10/1/1959

20d. INJURY OCCURRED: While at work ☐ Not while at work ☑

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): (Home)

20f. (City or town) (County) (State): Annapolis — Anne Arundel — Md.

21. I certify that (I) (the hospital) attended the deceased from Oct. 1959 to March 1, 1961, that (I) (he) last saw the deceased alive on 3/1/1961, and that death occurred at 5 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Albert L. Anderson M.D.
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 3/3/61

22c. PHYSICIAN'S NAME (Type): Albert L. Anderson
22d. ADDRESS: 44 Southgate Ave., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Mar-4-1961
23c. NAME OF CEMETERY OR CREMATORY: Monokin Presbyterian
23d. LOCATION (City, town, or county) (State): Princess Anne Md.

24. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons
ADDRESS: Annapolis Md.

25a. REC'D BY REGISTRAR DATE: MAR 6 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kruse

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2678

CERTIFICATE OF DEATH

02658

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 303 Balto-Annap. Blvd., Ferndale

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d. STREET ADDRESS: 303 Balto-Annap. Blvd., Ferndale
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY; Middle; Last VISKOCIL

4 DATE OF DEATH: Month March; Day 1; Year 1961

5 SEX: Female
6. COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 2 rd. Feb. 1875
9. AGE (In years last birthday): 86 yrs
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housework (ret.)
10b. KIND OF BUSINESS OR INDUSTRY: own Home
11. BIRTHPLACE (State or foreign country): Czeckoslovakia
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: (unknown) Bel
14. MOTHER'S MAIDEN NAME: Anna (unknown)

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): ////////
16. SOCIAL SECURITY NO.: none
17 INFORMANT: Address: Mr, George Viskocil Ferndale, Glen Burnie, M

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cerebral thrombosis
DUE TO
(b):
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 1 day

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from May 19 54 to Feb. 25 19 61, that (I) (we) last saw the deceased alive on Feb 25 19 61, and that death occurred at 12 A M. from the causes and on the date stated above

22a. SIGNATURE: C.R. MacDonald M.D.
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 3-3-61
22c PHYSICIAN'S NAME (Type): C. R. MacDonald, M.D.
22d. ADDRESS: 1411 Bonita Ave., Baltimore

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3rd. March'61
23c NAME OF CEMETERY OR CREMATORY: Bohemian National Cem.
23d LOCATION (City, town, or county) (State): Baltimore, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: F. J. Stapleton
ADDRESS: Glen Burnie, Md.
25a REC'D BY REGISTRAR DATE: MAR 6 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2674

CERTIFICATE OF DEATH

02653

1

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: A A
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riva
c. LENGTH OF STAY IN: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Manor House

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Md
b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 211 Scott Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Heartie; Middle: Corbett; Last: Ward

4. DATE OF DEATH: Month: 3 – Day: 22 – Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct 21-1871
9. AGE (In years last birthday): 89 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (County & State or foreign country): Crown Pt N.Y.
12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME: George Russell Corbett
14. MOTHER'S MAIDEN NAME: Elizabeth Bennett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Herman O. Werner (2) — Address:

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CEREBRAL THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 24 Hours

DUE TO (b): CEREBRAL ARTERIOSCLEROSIS — 5 YEARS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ARTERIOSCLEROTIC HEART DISEASE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) ~~(His hospital)~~ attended the deceased from ... JAN ..., 1956 to 22 MAR, 1961, that (I) ~~(He)~~ last saw the deceased alive on 22 MAR 1961, and that death occured at 1:50 PM, from the causes and on the date stated above.

22a. SIGNATURE: Edward S Beck — M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 3/22/61

22c. PHYSICIAN'S NAME (Type): Edward S. Beck
22d. ADDRESS: 71 Franklin St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-25-1961
23c. NAME OF CEMETERY OR CREMATORY: Woodlands Cemetery
23d. LOCATION (City, town or county) (State): Cambridge N. Y.

24. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons — ADDRESS: Annapolis Md

25a. REC'D BY REGISTRAR DATE: MAR 27 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2675

CERTIFICATE OF DEATH

02654

1. PLACE OF DEATH
a. COUNTY: AA — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brooklyn
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 300 Riverside Rd.

2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brooklyn
d. STREET ADDRESS: 300 Riverside Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Anne Middle: Marie Last: Wehberg

4. DATE OF DEATH: Month: 3 Day: 9 Year: 19 61

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Dec. 6, 1914

9. AGE (In years last birthday): 46 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Balto., Md.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Frederick V. Schofield

14. MOTHER'S MAIDEN NAME: Ida M. Dull

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Family Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

		INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Diabetes Mellitus	10 years +
DUE TO (b)	Arteriosclerotic C. V. D - Cardiac Failure	2 years
DUE TO (c)	Uremia - Kimmelsteel - Wilson -	3 months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from Sept 19 60 to Mar 9, 1961, that (I) (we) last saw the deceased alive on Mar 9 19 61, and that death occurred at 9 P M, from the causes and on the date stated above.

22a. SIGNATURE: Paul Schofield M.D. ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): Paul Schofield

22d. ADDRESS: 7301 Auchentoroly — 3/10/61

23a. BURIAL, CREMATION, REMOVAL (Specify): B

23b. DATE THEREOF: 3/13/61

23c. NAME OF CEMETERY OR CREMATORY: Holy Cross Cem.

23d. LOCATION (City, town, or county) (State): Brooklyn, Md.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: McCully Funeral Homes 130 E. Fort Ave. #30

25a. REC'D BY REGISTRAR DATE MAR 13 '61

25b REGISTRAR'S SIGNATURE: Clifton L. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
15M 9/59

1

Item 9 Film G204 4/4/01 iwk

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2676

Reg. Dist. No. 02655

M

1. PLACE OF DEATH
a. COUNTY: Anne Arundle
MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
b. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Je. sup

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 630 Arlington Ave., [illegible]

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Md. House of Correction Hospital

d. STREET ADDRESS: Baltimore, Maryland

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Samuel Middle L. Last Wernick

4. DATE OF DEATH: Month March Day 26 Year 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 12, 1905

9. AGE (In years last birthday): 55 yrs.

IF UNDER 1 YEAR: Months 7 Days 26

IF UNDER 24 HRS: Hours 22 Min. 35

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machine shop

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Unknown

12. CITIZEN OF WHAT COUNTRY? America

I

13. FATHER'S NAME: Simon Wernick

14. MOTHER'S MAIDEN NAME: Sira (Maiden name unknown) Wernick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Denies
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Hospital records
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure
DUE TO: Arteriosclerotic Heart Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January 30, 19 61 to March 26, 19 61, that I last saw the deceased alive on 3-26, 19 61, and that death occurred at 10:55 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Domingo C. Soronzan M.D.
ADDRESS (Street, city or town, state): 1213 Light St Balto 30
DATE SIGNED: 3/27/61

PHYSICIAN'S NAME (Type): Domingo Soronzan
1213 Light St. Baltimore 30, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mr 29-61
22c. NAME OF CEMETERY OR CREMATORY: Mt Carmel
22d. LOCATION (City, town, or county) (State): Balto Md

23. FUNERAL DIRECTOR'S SIGNATURE: Jack Lewis Jr
ADDRESS: 2100 Eutaw Place

24a. REC'D BY REGISTRAR DATE: MAR 29 '61

24b. REGISTRAR'S SIGNATURE: Clifton L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2677

CERTIFICATE OF DEATH

02657

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MILLERSVILLE
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Knollwood Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD. — b. COUNTY: A. A. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MILLERSVILLE
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MARTHA — Middle: E — Last: WILLIS

4. DATE OF DEATH: Month: 3 — Day: 2 — Year: 1961

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 5-13-1879

9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): N. CAROLINA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Wm W. Ezell

14. MOTHER'S MAIDEN NAME: MARY FREDERICK

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —
(If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. —

17. INFORMANT: Mrs. DAVID OWEN — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchial pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

491 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Rheumatoid Arthritis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan 16, 1961, to March 2nd, 1961, that (I) (we) last saw the deceased alive on Feb 27th 1961, and that death occurred at 5 p.m. from the causes and on the date stated above.

22a. SIGNATURE: Gerard Church M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/4/61.

22c. PHYSICIAN'S NAME (Type): GERARD CHURCH

22d. ADDRESS: 121 CATHERINE ST ANNAPOLIS Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 3/6/61
23c. NAME OF CEMETERY OR CREMATORY: HILLCREST
23d. LOCATION (City, town, or county) (State): ANNAPOLIS MD.

24. FUNERAL DIRECTOR'S SIGNATURE: John M. Bryant Sons
ADDRESS: Annapolis, Md

25a. REC'D BY REGISTRAR: DATE MAR 6 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2679 **CERTIFICATE OF DEATH** 02659

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 4 yrs. 5mos. 18 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1718 Llewellyn Avenue
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: — Last: Young

4. DATE OF DEATH: Month: 3 — Day: 14 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: January 27, 1904

9. AGE (In years last birthday): 57 yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: --------

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Daniel

14. MOTHER'S MAIDEN NAME: Ella ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): Unknown

16. SOCIAL SECURITY NO.: 219-03-6499

17. INFORMANT — Address: Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Status Epilepticus — INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Meningo-Vascular Syphilis

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Brain Syndrome Associated with CNS Syphilis & Convulsive Disorder

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) ----------

20c. TIME OF INJURY: Hour a.m. p.m. ---- Month, Day, Year ---- 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ---------

20f. (City or town) (County) (State): ----------

21. **I certify** that (I) (this hospital) attended the deceased from 7/26 8:56 A.M., to 3/14, 1961, that (I) (we) last saw the deceased alive on 3/14 19 61, and that death occured at 2 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Hildegarde H. Reissman M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 3/15/61

22c. PHYSICIAN'S NAME (Type): Hildegarde H. Reissman, M. D.

22d. ADDRESS: Crownsville State Hospital, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 3/18/61 — 23c. NAME OF CEMETERY OR CREMATORY: Mt. Calvary — 23d. LOCATION (City, town or county) (State): Cedar Hill, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: E. O. Wilson — ADDRESS: 1000 Brantley Ave.

25a. REC'D BY REGISTRAR — DATE MAR 22 '61 — 25b. REGISTRAR'S SIGNATURE: Wilbur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60